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

ID: 7MG1
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 **06/01/2015** (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:
X 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):

Documentation supporting the facility's request for a continuing waiver involving F458 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 06/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/15/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
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
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/09/2015** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 25, 2015

CMS Certification Number (CCN): 24E185

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

Dear Mr. Hagemeyer:

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 May 31, 2015 the above facility is certified for or recommended for:

98 Nursing Facility Beds

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

Your request for waiver of 458 has been approved based on the submitted documentation.

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.

Sincerely,

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

June 8, 2015

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

RE: Project Number SE185024

Dear Mr. Hagemeyer:

On May 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 30, 2015. This survey found the most serious deficiencies to be a pattern of widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 31, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 30, 2015, effective May 31, 2015 and therefore remedies outlined in our letter to you dated May 13, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K458 at the time of the April 30, 2015 standard 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
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

REVISED 2567b

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E185	A. Building B. Wing	5/31/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0159 Reg. # 483.10(c)(2)-(5) LSC	05/18/2015	ID Prefix F0161 Reg. # 483.10(c)(7) LSC	05/18/2015	ID Prefix F0176 Reg. # 483.10(n) LSC	05/21/2015
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	05/21/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	05/22/2015	ID Prefix F0333 Reg. # 483.25(m)(2) LSC	05/21/2015
ID Prefix F0441 Reg. # 483.65 LSC	05/22/2015	ID Prefix F0463 Reg. # 483.70(f) LSC	06/01/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/kfd	06/08/2015	18623	5/31/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/30/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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: 7MG1
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 **04/30/2015** (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:
X 1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B, 8 (L12)

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
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

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

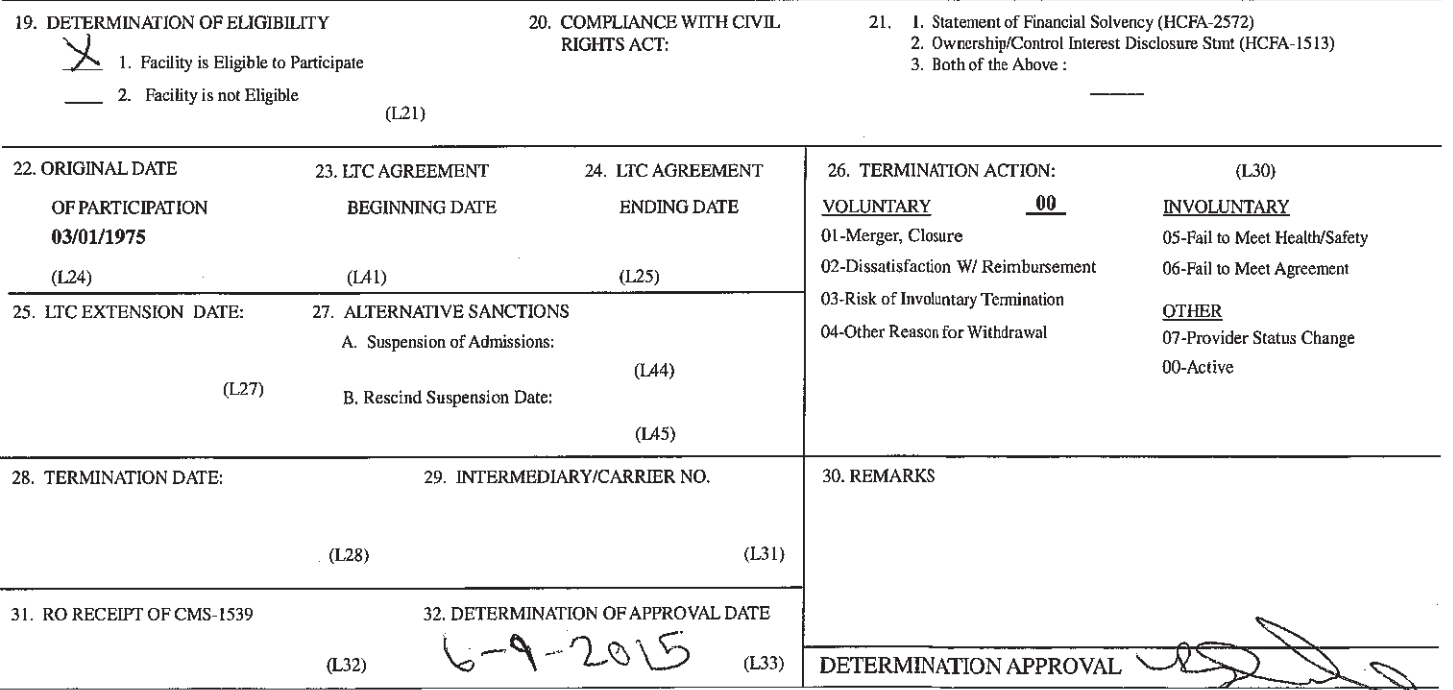
15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
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 :
Rebecca Wong, HFE NE II 05/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/08/2015 (L20)

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



19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
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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
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
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
6-9-2015
(L33)

DETERMINATION APPROVAL

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

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

6. DATE OF SURVEY **04/30/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
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13.Total Certified Beds **98** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 8** (L12)

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
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
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 :
Rebecca Wong, HFE NE II 05/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/08/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
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3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE (L41)

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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
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
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 13, 2015

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

RE: Project Number SE185024

Dear Mr. Hagemeyer:

On April 30, 2015, a standard survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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.

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

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 9, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 9, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 remedies will not be imposed. 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 July 30, 2015 (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 October 30, 2015 (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 electronic 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 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 ______	04/30/2015

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 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.	F 000		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 159		5/18/15

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

Electronically Signed | 05/20/2015

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 159	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents' personal funds were deposited in an interest-bearing account for 2 of 7 residents (R29, R91) reviewed for personal funds. Findings include: During interview on 4/29/15, at 12:56 p.m. the social services director (SS) stated she managed the residents' personal funds accounts and that the facility does not pay interest to the residents on their personal funds accounts. SS printed off	F 159	F159 Management of Personal Funds Effective April 1, 2015, interest has been accrued and paid to all residents who have a personal trust account at the facility. Interest will be paid to residents on a monthly basis. Resident Trust Fund Policy and Procedure (#2220) has been updated to reflect the interest bearing accounts. Completion Date: 05/18/2015	

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F 159	Continued From page 2 R29 and R91's personal funds accounts dated 12/1/14, to 4/29/15, which showed no interest had been deposited into R29's and R91's accounts. SS verified that R29's balance in the account on 12/1/14, was $92.00 and on 4/29/15, was $80.20. SS verified that R91's balance in the fund on 12/1/14, was $184.41 and on 4/29/15, balance was $313.34. SS also verified that both R29 and R91's account were consistently greater than $50.00 during that time frame. On 4/29/15, at 2:44 p.m. SS stated no concerns or grievances were filed from residents in the last year regarding money in their personal funds account. SS also stated she did not receive the bank statements for the residents personal funds account rather the chief executive officer (CEO) did. On 4/30/15, at 9:26 a.m. CEO stated the facility had not been paying the residents interest on their personal funds account. CEO also stated the residents funds account was a pooled account and that he had just switched to an interest bearing account but had not yet paid the residents any interest. CEO further stated he would go back and pay the residents the interest they should have received. On 4/30/15, the facility provided the Resident Trust Authorization policy dated 4/2014, which did not include any verbiage regarding an interest bearing account for the residents' personal funds.	F 159	Compliance Responsibility: Director of Social Services	
F 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the	F 161		5/18/15

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F 161	Continued From page 3 Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to secure a surety bond to protect 4 of 4 residents (R29, R55, R70, R91) who had a personal funds account managed by the facility. Findings include: Review of the Trust-Current Account Balance sheet indicated as of 4/29/15; R29 had a balance of $80.20 in the personal funds account R55 had a balance of $90.00 in the personal funds account R70 had a balance of $20.03 in the personal funds account R91 had a balance of $313.34 in the personal funds account During interview on 4/29/15, at 12:56 p.m. the social services director (SS) stated the facility held a surety bond for the residents' personal funds accounts which the chief executive officer (CEO) held. SS verified on the 4/29/15, Reconciling of Residents' trust funds that the balance of the fund was $48,199.44. SS stated she had previously asked the president to increase the surety bond to $70,000.00. On 4/29/15, at 3:07 p.m. SS provided papers and stated, "I talked to CEO, the surety bond was not large enough, it did not cover the entire personal funds accounts." The SS also stated the CEO	F 161	F 161 Surety Bond ¿ Security of Personal Funds Effective April 29, 2015, the surety bond was increased to insure the security of all personal funds of residents deposited with the facility. A bi-annual audit will be completed to ensure ongoing sufficient coverage. Completion Date: 05/18/2015 Compliance Responsibility: Director of Social Services Facility President / CEO	

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F 161	Continued From page 4 had called and asked for the bond to be increased from $40,000 to $50,000 to cover them all and provided a copy of the fax showing the request to increase the surety bond effective 2/1/15, expiration date 2/1/16, of $40,000 to $50,000. On 4/30/15, at 9:26 a.m. CEO stated he had not noticed the personal resident fund account had went over the $40,000 and just yesterday increased the surety bond to $50,000 to cover the amount of the residents' personal funds accounts. The policy provided by the facility's Resident Trust Authorization dated 4/2014, indicated no verbiage regarding a surety bond.	F 161		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to determine the practice of self-administration of Novolog (a fast-acting insulin) was safe for 1 of 1 resident (R2) observed to self-administer medications (SAM) during a medication administration observation. Findings include: On 4/29/15, at 7:25 a.m. registered nurse (RN)-A	F 176	F-Tag 176 It is the policy of Bywood East Health care to allow self-administration of medications when the resident has requested to do so. The resident¿s capabilities to self-administer medications will be assessed by the IDT within ten days of a request by the resident. Until the assessment is completed, the medications will be administered by the	5/21/15

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F 176	Continued From page 5 checked resident's (R2) glucose. RN-A washed her hands, applied gloves, and gave R2 an alcohol wipe. RN-A prepared R2's insulin pen and handed it to R2. R2 alcohol wiped her skin and gave herself the insulin. R2's admission date was 3/10/15, Minimum Data Set (MDS) admission assessment dated 3/23/15, indicated resident was cognitively intact. R2's diagnoses included diabetes mellitus and hypertension. Review of Self-administration of Medication Request dated 3/12/15, indicated resident had checked the box next to: "I decline to self-administer medication and I will inform the nursing staff if I choose to self-administer my medications at a later date." Copy was requested but not provided. Care plan dated 3/23/15, indicated "Focus: resident unable to SAM due to ongoing paranoid delusions. Staff set up and supervise med administration. Exception res. [resident] may SAM glucose tabs when on LOA [leave of absence]/pass. Goal: resident will receive all prescribed medications/treatments per M.D. [medical doctor] orders." Review of R2's Physician's Orders dated 3/24/15, revealed R2's orders were as follows: "-Insulin: accucheck QID [four times a day] (Novolog Flexpen) subcutaneous [SQ] - ins 3 x day: inject Novolog insulin as per sliding scale: if 0-200=0; 201-250=1 units; 251-300=2 units; 301-350=3 units; 351-400=4 units; greater than 400 give 6 units and update MD.***no sliding scale at HS [hour of sleep]***Diabetes Mellitus -Insulin: accuchecks -FYI: call MD if BS [blood	F 176	staff. Residents who self-administer medication will be assessed annually for their continued capability to administer their own medication. Resident (R-2)-was assessed by RN 5/4/15. Order was called and requested 5/4/14 and M.D. signed 5/7/15-Okay to self-administer insulin with supervision. Care plan was changed to reflect assessment and order. See attached documentation. To prevent occurrence nursing staff will be re-educated on the policy and procedure for self-administration of medication policy. See for #1423. All residents be assessed for self administration capability annually and as needed. Date of completion: May 21, 2015 Responsible for compliance: DON/ADON/MDS Coordinator.	

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F 176	Continued From page 6 sugars] over 200 at all accuchecks for 3 days, or <70 2x week. Diabetes -Insulin: Levemir flexpen 16 units subcutaneous (SQ) - Ins BID [twice a day] Diabetes -Insulin: Novolog flexpen (Aspart insulin) 100 unit/ML [milliliter] subcutaneous (SQ) - Ins Q [every] AM [morning]: inject 4 units every morning before breakfast. Diabetes -Insulin: Novolog flexpen (Aspart insulin) 100 units/ml subcutaneous (SQ) - ins BID: inject 5 units SQ before meals ***lunch and supper*** Diabetes." The undated care plan comments indicated "self administration of medications: resident is unable to SAM due to ongoing paranoid delusions. Staff set up and supervise medication administration. Exception res. May SAM glucose tabs when on LOA/pass." On 4/29/15, at 12:54 p.m. spoke with RN-B and asked if resident had received an assessment to self-administer insulin. RN-B stated there was no assessment in the chart. Will have to look in progress notes for physician order. On 4/30/15, at 2:54 p.m. during an interview with licensed practical nurse (LPN)-B stated she thought it should be care planned for the resident to give herself insulin, and perhaps the care plan may not be done yet. On 4/30/15, at 2:52 p.m. interviewed R2 who stated she had given herself insulin since she has been here. On 4/30/15, at 3:45 p.m. interviewed assistant director of nursing (ADON) who stated before doing insulin injections they should do an	F 176		

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F 176	Continued From page 7 assessment to see if the resident can do it, then get a physician order for the resident to self-administer insulin injections.	F 176		
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 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 interview, observation and documentation review, facility failed to revise the care plan to reflect insomnia for 1 of 1 resident (R38). Findings include: R38 was admitted to the facility on 1/30/13, with	F 280	F-Tag 280 It is the policy of Bywood East to monitor sleep patterns with complaints of insomnia or those who are currently on sleep aids Resident (R38) was ordered Benadryl on 4/4/2015 sleep monitoring was initiated for R38.	5/21/15

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F 280	Continued From page 8 admission diagnoses of chronic paranoid schizophrenia, lung disease and heart disease per the Admission Record. The annual Minimum Data Set (MDS) dated 2/13/15, indicated R38 was cognitively intact, moderately depressed, and experienced hallucinations and delusions. The Care Area Assessment (CAA) dated 2/23/15, indicated R38 had expressed feeling depressed occasionally, had difficulty sleeping, a poor appetite every day over the past two weeks, and difficulty concentrating on things every day. The care plan dated 3/10/15, lacked a diagnosis, goals or interventions for insomnia. The Quarterly Documentation and Care Plan Review dated 2/13/15, indicated R38 had an increase in paranoid delusional statements about money and became argumentative about it. R38 was started on Risperdal 2 mg (milligrams) every day for increased paranoia, and he had complained that he was too sleepy, but also stated that he can talk and think better. R38 had a follow-up appointment with psychiatrist on 8/20/14, and Risperdal was decreased to 1 mg and he had no complaints with his medications since then. He was seen by his psychiatrist last on 1/13/15, with no changes. The Physician Orders dated 4/4/15, directed the staff to administer Benadryl 25 milligrams (mg) at bedtime for sleep. On 4/29/15, at 7:44 a.m. R38 introduced himself to surveyor shaking my hand and told me to enjoy breakfast. A staff member approached R38 and	F 280	An audit will be conducted on all residents receiving sleep medications to ensure sleep monitoring is in place. Nursing staff will be re-educated on the Sleep Log Policy and Procedure May 21, 2015. See form #1317 All medications including sleep aids will be reviewed quarterly in conjunction with care conferences to ensure ongoing compliance. Date of completion: May 21, 2015 Responsible for compliance DON/ADON/MDS Coordinator	

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F 280	Continued From page 9 they conversed pleasantly. -At 7:46 a.m. TMA-A (trained medication aide) conversed pleasantly with R38 and he also was in return. -At 7:56 a.m. TMA-A stated R38 will out of no-where would say do not talk to me, but normally in good mood. We let him walk away and re-approach later; R38 will mumble to self; if re-approach did not work we send other staff. On 4/30/15, at 12:16 p.m. R38 stated that he has not been sleeping well but they are doing something about it. Stated they started a new medication to help him sleep; last night was the first night he got it and it did help him sleep a little longer. The April 2015 Medication Administration record (MAR) indicated last night (4/29) was the first night R38 received Benadryl. -At 2:11 p.m. licensed practical nurse (LPN)-B stated R38 was complaining to medical doctor that he wasn't sleeping. R38 "never says anything to staff here about not being able to sleep." Typically we do a sleep log before sleeping meds are started, it is usually the doctor that orders the sleep log or if a patient complained about not sleeping we would just do one, but R38 never complained about not sleeping to us. I did tell the night staff they need to watch to see if he was sleeping now at night and record it in the progress notes and it was reported to me that morning that he slept last night. -At 3:24 p.m. the assistant director of nursing (ADON) stated facility practice was to always do a sleep study beforehand (before starting sleep meds) if aware of issues. When insomnia first noted by medical doctor on green note (referral form) dated 4/11/15, the nurses should have started a sleep study at that time. I was not aware that R38 was started on Benadryl and it was not a	F 280		

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F 280	Continued From page 10 good medication to have elderly residents on. I am not sure what the director of nursing (DON) had communicated to nurses as far as reporting different meds that are started. -At 2:42 p.m. registered nurse (RN)-B stated Start sleep medication because it was ordered. RN-B did not know who determined what resident got put on a sleep log. RN-B further stated "sometimes do sleep logs on people if we notice they are not sleeping well, or we will have MD order sleep log. Sometimes do this to determine if they even need a sleep med before it is started. -At 4:39 p.m. the consultant pharmacist (CP) stated "encourage all facilities to do a sleep study when first start a hypnotic and ideally before started also." "Use of Benadryl depends on diagnosis. I do not personally like to see it used for sleep in older patients."	F 280		
F 323 SS=D	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 implement new interventions for 1 of 3 residents (R67) reviewed for accidents. Findings include:	F 323	F-Tag 323 Bywood ensures the resident¿s environment remains free of accidents hazards as possible and that the adequate supervision and assistive devices are provided to prevent accidents.	5/22/15

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F 323	Continued From page 11 R67 was admitted to facility on 3/12/14, per the Admission Record. The annual Minimum Data Set (MDS) dated 2/4/15, indicated orthostatic hypotension, gastroesophageal reflux disease, depression, schizophrenia, and asthma. MDS indicated R67 was cognitively intact and mood assessment indicated R67 was tired and has poor appetite. On 4/29/15, at 8:19 a.m. observed resident to be sleeping in his bed and at 2:40 p.m. resident was observed sleeping in his bed. On 4/30/15, at approximately 10:00 a.m. resident observed to be participating in morning activity session. The fall risk assessment dated 2/4/15, indicated R67 was unsteady with transitions from seated to standing position and with ambulation. Primarily used wheelchair for locomotion, independent with propelling self, ambulates in room independently. R67 had a mobility bar on bed to maintain independence with transfers and bed mobility. R67 Ambulated in hallway with two staff and walker when he did not refuse. R67 had history of numerous falls over the past six months, and mostly were during times of transferring self. R67 had worked with physical therapy in the past as he walked with knees bent and often they just give out on him. R67 had score of 12, which was indicative of being a high fall risk. R67's care plan dated 2/24/15, indicated potential for falls related to history of falls and psychotropic medications. R67 was unsteady with transition from seated to standing position, does not requires hands on assist to steady self. Ambulates short distances in room independently and with staff assist in hallway with walker. R67	F 323	Resident (R67) has DX of Ankylosing Spondylitis and has periods of weakness however, remains independent with mobility with use of W/C for highest level of independence. Any falls/incidents are evaluated by the IDT, interventions and goals discussed and care planned for resident¿s safety. Fall risk assessment completed 5/7/15 and scored 12. Resident R67 ambulates in room independently, has a mobility bar on bed to maintain independent with transfers and bed mobility and ambulates in the hallway with two staff and a walker, when he does not refuse. Anti-roll back W/C locks were ordered for transfer safety. All nursing staff will be educated on the use of anti-rollback wheel chair locks in Nurse/TMA/NAR meetings scheduled for 5/21-22/15. Date of completion: 5/22/2015 Responsible for compliance:DON/ADON	

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F 323	Continued From page 12 used a wheelchair for locomotion, independent with propelling self. R67 had a mobility bar on bed for transfers and bed mobility. R67 also had a fall on 5/31/14, in which R67 had misjudged placement of toilet seat, no injury. The falls have decreased since use of wheelchair. Admission fall risk assessment score 14, which was high risk, and current assessment score 9 (10 and over was high risk). The goal for R67 was to have no falls with serious injury, intervention was to encourage and educate to use call light for assistance when feeling weak. Care area assessment (CAA) dated 4/30/15, indicated R67 had difficulty maintaining balance, and had impaired balance. R67's incident reports were reviewed and the following incidents were noted: - On 5/31/14, fell to bottom when turning to sit on commode, denied hitting head, no injuries, reminded to ask for assist if legs feel weak, intervention was to ask for standby assist when legs feel weak, started new walking program two times daily (BID), intervention educated and reminded to ask for assist when going to bathroom. - On 8/30/14, at 7:30 p.m. resident fell in room by doorway, stated was moving roommates wheelchair, went to sit down in wheelchair, brakes not locked, slid to buttocks, did not hit head, had shoes on. Interdisciplinary team (IDT) felt was due to not locking brakes when transferring. Goal: resident will lock wheelchair brakes when not in motion/prior to transfers. Interventions remind and encourage locking wheelchair brakes when not in motion/prior to transfers. - On 9/4/14, at 1:50 p.m. resident at front door,	F 323		

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F 323	Continued From page 13 had gone through door went out of wheelchair onto hands and knees, no bumps or bruises, scratch right knee/shin area, denied pain, neuros, vital signs completed. Medical doctor (MD) all parties' notified, no obvious injury. Intervention: educated and remind to apply brakes and back up to feel legs on wheelchair before sitting for safety. Second fall at 4:00 p.m. in resident's room, reported had fallen attempting to sit and wheelchair rolled out from under him, brakes unlocked, did not hit head, no bruises, notified MD order given to send to Emergency Department (ED) for evaluation. Intervention was educated and reminded to apply brakes and back up to feel legs on wheelchair before sitting for safety. - On 9/24/14, at 10:20 a.m., was in room went to sit in wheelchair, wheelchair not locked sat on floor, did not hit head, all parties notified, no injury. Intervention: Nursing/staff place signs in room and on wheelchair arms to remind to lock wheelchair prior to transfers. - On 10/6/14, at 11:45 a.m. was in room, staff assisted to lock wheelchair, when returned found resident on floor stated was transferring self and fell. Wheelchair was unlocked, did not realize unlocked, thought it was locked, no shoes on, no injury. Nursing/staff to remind to wear shoes for transfers and ambulation and read and comply with reminder notes to check brakes for locked position before transfers. - On 10/16/14, at 9:25 a.m. resident found on bottom beside bed, stated was trying to get up to void and slid to bottom, did not hit head, wheelchair locked, assisted by two staff to bathroom. Intervention: was offered and accepted room change with more space. - On 10/22/14, at 11:45 a.m. resident stated went to bathroom, legs got weak and sat down on	F 323		

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floor, all parties notified. Intervention: remind and encourage using urinal or asking for assistance to bathroom.
- On 11/19/14, at 11:00 a.m. resident was in bathroom, stated wanted to use bathroom was transferring himself from wheelchair to toilet, pulled call light after certified nursing assistant (CAN) found him on floor. Did not hit head, had socks and shoes on, clothing fit appropriately, no injury occurred, all parties notified. Intervention: resident will call for assistance to toilet and use call light before transfers.
- On 1/19/15, at 5:15 a.m. resident found sitting on buttocks bedside. Reported was trying to put on pants and slid off bed onto floor, had scrape on right knee from trying to get himself up on his own. Intervention: educate and remind to use call light for assistance with activities of daily living (ADL)'s cares as needed (prn).
- On 4/22/15, at 2:30 p.m. resident found in first floor main bathroom on right side with pants down, was trying to pull up pants in the dark (electricity was out) and fell to bottom, hit backside on toilet. Intervention: remind resident to ask for assistance especially when dark.

On 4/29/15, At 2:41 p.m. LPN-B stated R67 was doing better with falls, fell when power was out, and knows to ask. He mainly loses balance when trying to pull up pants, and needs to ask for help.
- at 2:43 p.m. nursing assistant (NA)-A stated resident did not have behaviors, and had a fall recently when power went out.

On 4/30/15, at 9:51 a.m. licensed practical nurse (LPN)-B stated they rearranged R67's room, and moved him to larger room which was uncluttered, and have him ask for help. She stated he mainly pulls up pants and sits down when wheelchair

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was unlocked.
- At 4:05 p.m. assistant director of nursing (ADON), stated resident had been walking now with staff and last fall was due to power outage. ADON stated it had not been discussed to get anti-rollback system (prevents wheelchair from rolling backwards) on wheelchair. She stated he had been doing better with his falls recently.

Bywood East Health Care Policy and Procedure Following Resident Accident/Incident indicated: "it is the policy of Bywood East to fill out an incident report for any resident who has a fall or incident either away from or on the premises of Bywood East Health Care. Procedure: a staff person shall call a nurse to the scene to determine the seriousness of the accident/incident. 1. Give First Aid as appropriate. 2. Nurse will determine if an emergency medical services (EMS) call is indicated. 3. An initial set of vital signs shall be taken ... 5. Note any supporting information from the incident form that may have contributed and make appropriate interventions. 6. Notify MD as appropriate. 7. Notify family or emergency contact person. 8. Notify Administrator immediately of any incident. 11. If incident/fall results in a major injury, a CEP report must be completed. 12. Report interventions on care plan to Charge Nurse on next shift. 14. 24-hour follow up is done by checking resident ' s condition and the status of new interventions. 15. Incident Review will be completed and reviewed by the Interdisciplinary Team at their next meeting."
Bywood East Health Care Fall Risk Assessment Policy and Procedure dated rev 1/9/14, indicated policy is "to assess a resident's potential for falls upon admission, quarterly and as needed (PRN) as indicated by the assessment." Policy is "to

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F 323	Continued From page 16 provide protective and preventive care for problems identified from assessments. Procedure 1. Assess potential for falls using the fall risk assessment, 2. Identify specific underlying causes for falls. 3. Record and care plan potential risks 4. Develop treatment plan 5. Implement plan 6. Assess and document effectiveness of treatment plan 7. Review plan and revise as needed. 9. The IDT Incident Review Committee will review the incidence of falls ... and attempt to assist in reduction of resident falls by suggesting additional interventions. 11. The medical record will be reviewed and the incident reports assessed for any pattern or preventable causes."	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 resident's (R50) reviewed for unnecessary medications was free of significant medication error. The facility's process for double checking insulin medication sheets prior to the new month start failed to identify an order change, and failed to prevent incorrect insulin sliding scale doses from being given for four days in April 2015. Findings include: R50 was admitted to the facility on 2/13/07, with admission diagnoses of diabetes, obesity, schizophrenia and depression per the Admission	F 333	F-Tag 333 Resident (R50) received incorrect sliding scale for four days. No untoward reactions occurred. Order was corrected and restarted on 4/4/2015. M.D. was notified of error and there were no new orders. All staff involved were individually approached prior to signing error report. Bywood East will ensure that all residents have received accurate medication and dosages per M.D. orders by audit of each individual charts orders and medications sheets which will be completed by 6/1/2015.	5/21/15

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F 333	Continued From page 17 Record. R50's insulin orders dated 10/16/14, indicated Novolog insulin 16 units (u) under the skin (sq) three times a day before meals (also has sliding scale); in addition an order for Lantus insulin (long acting) 54u at 6:30 a.m. and bedtime. The sliding scale Novolog insulin dated 11/13/14, directed staff to provide the following sliding scale (SS) insulin coverage, based on blood glucose (BG) monitoring four times a day. BG 151-200 =4u; 201-250=6u; 251-300=8u; 301-350=10u; 351-400=12u; over 401=14u and call the doctor (MD). The Care Area Assessment dated 12/30/14, indicated R50 had diabetes, was obese, received a therapeutic diet for diabetes and heart disease. R50 was hospitalized 3/7/15 through 3/12/15, for lung disease with acute worsening, diabetes uncontrolled, and worsening heart failure. During the illness R50 received prednisone (a drug that treats allergic disorders and acute lung illness) that can cause a rise in blood sugar levels. Upon return from the hospital R50's SS insulin coverage was increased. A hand written order was implemented: for BG 150-200=6u; 201-250=8u; 251-300=10u; 301-350=12u, 351-400=14u, over 400 give 16u and call MD. On 3/22/15, the computer generated April 2015 order set that had the aggressive SS insulin orders verified by the first check nurse correctly. On 3/25/15, the prior aggressive SS insulin order was discontinued and R50 resumed her usual scheduled insulin dosing and a new SS insulin	F 333	All nurses will be re-educated on receiving and transcribing orders by following policy and procedure of audits of physician¿s referral and orders. (See form #1396). Completion Date: May 21, 2015 Responsible for Compliance: DON/ADON	

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order was written. For BG 150-200=2u; 201-250=4u; 251-300=6u; 301-350=8u; 351-400=10u; over 400=12u and call MD. That new SS insulin order set was implemented on 3/25/15.

The care plan revised 3/26/15, indicated at risk for chronic illness, heart disease and complications of altered blood glucose related to extreme obesity and diabetes type II. R50 was encouraged to attend activities, eat three meals/day, participate in exercise groups and follow a counted carbohydrate, no added salt diet with evening and bedtime snacks. R50 received Lantus and Novolog insulin.

On 3/30/15, the second check nurse did not identify that an order change for the SS coverage had occurred. The computer printed aggressive SS insulin coverage (that had been discontinued) was approved by the second check nurse incorrectly. The printed medication record (with the wrong SS insulin coverage) was implemented on 4/1/15.

The Minimum Data Set (MDS) dated 3/31/15, indicated R50 was cognitively intact, minimally depressed, and experienced hallucinations and delusions.

On 4/1/15, the first incorrect dose of insulin SS coverage was given at 6:00 a.m. The BG was 150, R50 received 6u of SS coverage instead of the 2u that should have been administered. At 11:00 a.m. the BG was not recorded (just a line in the result box), however it was documented that 6u of SS insulin was given instead of the 2u that should have been administered. At 4:30 p.m. the BG was 76 and no SS coverage was given. At

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9:00 p.m. the BG was 99, no SS coverage was given.

On 4/2/15, the 6:00 a.m. BG was 154 and 6u of SS coverage was given, 2u should have been administered. At 11:00 a.m. the BG was not recorded, 5u were administered (it is unclear how many units should have been given since 5u was not an option on the SS insulin coverage). At 4:30 p.m. the BG was 105 and no SS insulin was administered. At 9:00 p.m. the BG was 118 and no SS insulin was administered.

On 4/3/15, the 6:00 a.m. BG was 184 and 6u of SS coverage was given, 2u should have been administered. At 11:00 a.m. the BG was 173 and 6u of SS coverage was given, instead of the 2u which should have been administered. at 4:30 p.m. the BG was 88 and no SS coverage was given. At 9:00 p.m. the BG was 118 and no SS coverage was given.

On 4/4/15, the 6:00 a.m. BG was 174 and 6u of SS coverage were given instead of the 2u that should have been administered.That was the last incorrect dose given, the SS insulin coverage was crossed out, a notation was added "changed on 3/25/15" and the new (accurate) SS insulin coverage was hand written on the insulin administration record. No other insulin administration errors were noted.

On 4/29/15, at 12:52 a.m. registered nurse (RN)-B stated "the orders were usually printed around the 20th of the month, and a first check was done for changes/updates." "Then for insulin administration the second check was done by an RN, but I am not sure when that was done." RN-B was not aware that the first four days of April the

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F 333	Continued From page 20 SS coverage of insulin reverted to the more aggressive SS, which had been in place during Prednisone (steriod medication) administration. RN-B stated "normally the RN that checks them catches everything." -At 2:30 p.m. RN-C reviewed the insulin administration record for R50 and stated she gave the wrong dose on Friday 4/3/15. The BG at 11:00 a.m. was 173 and she had given 6u however at the time the only SS coverage listed on the insulin administration record was the aggressive SS. RN-C noted that the second check was done after the order change on 3/25/15, and should have been caught. 4/30/15, at 2:45 p.m. the assistant director of nursing (ADON) stated she had reviewed the errors with RN-C, and was aware errors in administration and transcription had occurred for the first four days of April, after the SS insulin coverage orders had been changed on 3/25/15. The ADON stated the insulin order should have been caught on the second check review that was completed on 4/30/15. -At 2:50 RN-D, identified on the employee sheets only as medical records, stated she did the second check with the insulin book (kardex), and if that SS coverage was there, she would have made the change and written it in. RN-D further stated she "also checked the physician orders in Point Click Care (computer program) and reviewed the electronic progress notes looking for changed orders." RN-D verified she "did not go to the physical chart to check for order changes, because it should have been with the insulin book." The undated Medication Administration (Clinical Orientation) from, indicated the goal was to	F 333		

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F 333	Continued From page 21 administer medications safely....Follow the "5 rights" of medication administration -right patient, right drug, right dose, right time and right route. The Policy and Procedure for Administration of Insulin dated 9/09, did not address the double check procedure for reviewing the insulin administration record against the current physician orders.	F 333		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		5/22/15

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F 441	Continued From page 22 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure clean linen was covered and maintained in a sanitary manner to spread infection. This had the potential to affect all 97 residents currently residing in the facility. Findings include: On 4/27/15, at 2:14 p.m. linen cart near basement laundry room was observed uncovered, with linens stacked on top of it. - At 3:43 p.m. the laundry cart was observed in same location in basement, which remained uncovered with linens stacked on top of it. On 4/28/15, at 4:30 p.m. the linen cart was observed near basement elevator next to small rolling cart. The linen cart was covered except on end toward wall, which was touching small rolling cart. Small rolling cart observed to be covered with black to brown debris, wiped finger across it, and picked up black debris on finger. On 4/30/15, at 12:21 p.m. housekeeping stated staff usually should keep them covered unless they are taking linens to a room. The pink cart	F 441	F-Tag 441 It is the policy of Bywood East to establish and maintain and infection program to provide a safe, sanitary, and comfortable environment. On 4/27/2015 a linen cart was in the basement uncovered and on 4/28/2015 a linen cart was placed next to a dirty cart and one touched the other. Staff was instructed to cover cart and place apart from the cart considered dirty. Staff was reminded clean linens carts cannot be uncovered or placed by dirty carts. Environmental and housekeeping services will perform random audits on a monthly basis to ensure infection control process is being conducted. Date of completion: May 22, 2015 Responsible for compliance: Director of Environmental services/DON	

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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 441	Continued From page 23 was usually not next to it. She stated did not expect to have carts looking like that and would remind staff on each floor to always cover linen carts. - At 12:25 p.m. Housekeeping stated all bed linens and towels go to outside laundry service, and puts in order Monday, Wednesday, and Friday. The clean linen arrived covered with plastic bags. We just do residents personal clothing here. They have hampers for towels and personal laundry in each units shower room, and bring them downstairs when they are full to be washed. - At 3:47 p.m. assistant director of nursing (ADON) stated carts should be covered with a sheet before linen was distributed. An undated facility policy entitled Infection Control indicated: "Proper infection control guidelines laundry department -Handle soiled linen little as possible -Clean linen kept in enclosed cabinets -Transport clean linen in enclosed cart."	F 441		
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: Based on observation, interview, and document review, the facility failed to ensure 11 of 38 bedrooms that met the required room size of at least 120 square feet for a single resident rooms	F 458	Annual Waiver Request See Attached Letter from Administrator	~~5/20/15~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E185	A. BUILDING ____ B. WING ____	04/30/2015

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F 458	Continued From page 24 and 80 square feet for a double room. Findings include: During the entrance conference on 4/27/15, at 1:30 p.m. the administrator verified that the facility had a room size waiver in place for 11 rooms in the facility. The room numbers were: 102, 107, 108, 109, 202, 208, 301, 302, 307, 308, and 309. During the survey interviews were conducted in 7 of the 11 rooms and there were no concerns expressed. During the survey from 4/27/15 through 5/1/15, the residents nor family had concerns or complaints related to the room size.	F 458		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to identify a non-functioning call light for 3 of 3 residents (R39, R103, R70) who had a non-functioning call light reviewed for environmental concerns. Findings include: On 4/27/15, at 1:22 p.m. when a bathroom call light cord was pulled, it did not light up. Nursing assistants (NA)-B and NA-C came to room to turn call light off. NA-B pulled call light cord and	F 463	F463 ¿ Resident Call System Bywood East Health Care does provide a call/communication device for each resident bed and resident bathroom. The system is monitored at least monthly and staff are educated to report any issues to the Environmental Services Director immediately. Bywood East Health Care will re-educate staff on reporting call/communication device issues to the Environmental	5/31/15

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	24E185	A. BUILDING ______ B. WING ______	04/30/2015

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F 463	Continued From page 25 confirmed it did not work. When asked, NA-B stated she expected call light to be working in the bathroom and reported it. The call lights did not work for R39, R103, and R70. Quarterly Minimum Data Set (MDS) dated 4/14/15, indicated R39 was independent with walking, transfers and toileting. Quarterly Minimum Data Set (MDS) dated 4/14/15, indicated R108 was independent with walking, transfers and toileting. Quarterly Minimum Data Set (MDS) dated 4/14/15, indicated R70 was independent with walking, transfers and toileting. On 4/30/15, at 11:56 a.m. during environment tour, Environmental Services confirmed bathroom call light to be working, and stated it was repaired by call light repair services on 4/28/15. Environmental Services further stated all building call lights were checked monthly, and were last checked on 4/7/15. When asked, Environmental Services stated facility did not have a call light policy.	F 463	Services Director immediately. The call/communication system will be monitored bi-weekly for proper operation. Completion: May 31, 2015 Compliance: Environmental Services Director	

BYWOOD EAST HEALTH CARE

Voice 612-788-9757
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3427 CENTRAL AVENUE N.E.
MINNEAPOLIS, MINNESOTA 55418-1297

May 20, 2015

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 requi[illegible]ment F458 for the following rooms: 102, 107, 108, 109, 202, 208, 301, 302, 307, 308, and 30[illegible]

We believe that the room sizes are in accordance with residents' special [illegible]eeds and will not and have not endangered the health or safety of the residents. Emergency p[illegible]sonnel such as firemen and paramedics have not had any issues maneuvering in the roo[illegible]s and we move objects as necessary in emergency situations.

Additionally we have implemented numerous practices to assure these r[illegible]oms stay as clutter free, organized and safe as possible and additional storage is provided to [illegible]ach 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 612-81[illegible]2196.

Thank you.

Sincerely,

Randal L. Hagemeyer
Administrator

GIVE AND HELP LIVE
Equal Opportunity Employer

FE 185023

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 ______	04/30/2015

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. 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 94 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.