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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IR3H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 **07/092018** (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
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 08/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 08/08/2018 (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
08/01/2018
(L33)

DETERMINATION APPROVAL

CCN: 24E 185

On May 23, 2018 a standard survey was completed at this facility. The highest s/s was an F.

On June 6, 2018 an abbreviated standard survey was completed by the Department of Office of Health Facility Complaints. The highest scope and severity was a G cited at F 760. This facility continues to be non-compliant at the time of this survey.

On June 13, 2018 a continuing waiver request was received for F 0912 Bedrooms Measure At Least 80 sq. Ft/resident. This department is recommending to CMS approval of this waiver.

On July 9, 2018 the Department of Health and July 31, 2018 the Department of Health, Office of Health Facility Complaints completed revisits and found this facility to be in substantial compliance.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 24E185

August 8, 2018

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective July 2, 2018 the above facility is recommended for:

98 Nursing Facility I Beds

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

Your request for waiver of F 912 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered August 8, 2018

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

RE: Project Number SE185027 and HE185047

Dear Ms. Thorson:

On June 20, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 25, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 23, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of June 20, 2018, 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 August 23, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on May 23, 2018, and an abbreviated standard survey completed on June 6, 2018 by the Minnesota Department of Health, Office of Health Facility Complaints. The most serious deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 9, 2018, the Minnesota Department of Health and on July 12, 2018 Minnesota Department of Public Safety 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 May 23, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 2, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 23, 2018, as of July 2, 2018.

On July 31, 2018 the Minnesota Department of Health, Office of Health Facility Complaints 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 an abbreviated standard survey, completed on June 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 2, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard

survey, completed on June 6, 2018, as of July 2, 2018.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of June 20, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- State Monitoring effective June 25, 2018, be rescinded. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 23, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 23, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 23, 2018, is to be rescinded.

In our letter of June 20, 2018, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 23, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 2, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency cited under F 912 at the time of the May 23, 2018 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 PCR with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IR3H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 **05/23/2018** (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 (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
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (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):

17. SURVEYOR SIGNATURE — Date:
Amy Charais, HFE NE II — 06/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 08/01/2018 (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
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
Health Room Waiver Request sent to CMS - 08/01/2018

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IR3H

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8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35)
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___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

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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)

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Amy Charais, HFE NE II 06/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 08/01/2018 (L20)

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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
8/1/2018 (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 8, 2018

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

RE: Project Number SE185027

Dear Ms. Thorson:

On May 23, 2018, 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 electronically attached CMS-2567 whereby corrections are required.

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:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - 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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 July 2, 2018, 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 July 2, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (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 August 23, 2018 (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 23, 2018 (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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

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 _____	05/23/2018

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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 5/20/18, through 5/23/18 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		7/2/18

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

Electronically Signed | 06/18/2018

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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E 037	Continued From page 1 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and	E 037		

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E 037	Continued From page 2 volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement,	E 037		

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E 037	Continued From page 3 and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure and provide initial training in emergency preparedness (EP) policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. This had the potential to affect all 83 residents who resided in the facility. Findings include: On 5/23/18, at 12:30 p.m. the EP program revised 5/9/18, was reviewed with the administrator. During review of the three ring binder which contained all the EP program policies, procedures and training information, it was revealed 41 staff members had not received	E 037	The administrator reviewed the emergency plan in Resident Council on 6/14/18 The Safety Committee reviewed the plan for presentation on 6/15/18 Emergency plan overall review will be discussed at an All Staff Meeting to be held June 26, 2018 and repeated on June 28, 2018. The orientation program for new employees will be revised to add this information by July 2, 2018. To monitor, Administrator or designee will randomly question staff as to their knowledge of emergency procedures on a weekly basis. Results will be presented to QAPI in July	

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E 037	Continued From page 4 or been provided initial EP training. The administrator verified and stated she was going to check with staff development. The administrator stated the training had been provided on 9/13/17, through 9/14/17. When asked if any follow up had been completed for staff who had not attended she stated she would check with staff development. On 5/23/18, at 1:19 p.m. the director of social service (DSS) stated she did not know where the former staff development nurse had put the all the training attendance however, she was going to try and locate the information. -At 2:48 p.m. the DSS approached and stated she had not found anything. She stated the facility had completed more training in April 2018, however not all staff had attended the training. DSS provided attendance for "Severe Weather Watch/Warning Attendance Report" dated 4/12/17, and 4/20/17.	E 037	and again in October, 2018. If needed, monitoring will continue.	
F 000	INITIAL COMMENTS On 5/20/17 through 5/23/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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.	F 000		

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F 000	Continued From page 5 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		7/2/18

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F 550	Continued From page 6 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R36) was provided privacy during cares. Findings include: R36's quarterly minimum data set dated 3/20/18, indicated she was cognitively impaired and required extensive assist of two staff for transfers and toileting. R36's care plan dated 3/20/18, identified dependence on staff for assistance with all cares and directed staff to provide extensive assistance with hygiene which included pericare, dressing and hygiene related to daily tasks. During observation on 5/22/18, at 10:33 a.m. nursing assistants (NA)-B and NA-C entered R36's room. Both NA's approached R36 and cued her they were going to get her up for lunch. NA-B took the covers off and as R36 was swinging her feet to a sitting position, both NA's identified R36 had been incontinent of stool. NA-B and NA-C applied gloves and a transfer belt around R36's waist then assisted R36 to stand and transfer to the wheelchair. At 10:36 a.m. NA-C wheeled R36 into the shared bathroom and cued R36 to hold onto the grab bar as she stood. NA-A then removed the incontinent pad and	F 550	Bywood East ensures residents privacy during cares. All Nursing staff have reviewed the expectations related to privacy during personal cares. Direct care staff were interviewed to identify other areas of concern and solutions developed. A privacy curtain will be placed in the tub & shower room and daily a supply of hospital gowns will be made available in the same room. A dignity audit was developed and reviewed with staff. The interdisciplinary team will audit weekly for four weeks, monthly for 2 months and then as needed. Continued compliance will be the responsibility of the Director of Nurses, Staff Development Nurse, and interdisciplinary team. Compliance data will be presented to the QAPI team in July and October, and then ongoing as needed.	

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F 550	Continued From page 7 tossed it in the garbage. NA-C then pulled the portable toilet seat behind R36 and cued R36 to sit. NA-C then wheeled R36 to the toilet and as R36 sat on the toilet and NA-C and NA-A removed R36's dress which was soiled. From 10:38 a.m. to 10:41 a.m. R36 sat on the toilet chair naked as she spoke in a language NA-A and NA-C did not understand. Without attempting to cover R36, NA-A provided care while she sat on the toilet naked. At 10:42 a.m. NA-A and NA-C wheeled R36 to the grab bar and cued her to stand. R36 was still exposed and staff did not attempt to cover her. NA-A applied a clean pad and then sat R36 in her wheelchair and put a clean dress on her. On 5/22/18, at 12:23 p.m. NA-C acknowledged they had left R36 naked during the cares. NA-C stated "we should have covered her." -At 12:27 p.m. NA-B stated they were supposed to provide R36 privacy by covering her. -At 12:31 p.m. NA-A stated she was supposed to provide residents with privacy and acknowledged they were supposed to have used a towel or gown to cover R36 as they were waiting other NA-B to bring another dress. On 5/22/18, at 2:43 p.m. the director of nursing stated the NA's should have applied a gown on R36 to promote dignity.	F 550		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical	F 583		7/2/18

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F 583	Continued From page 8 records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review facility failed to ensure resident privacy for 4 of 4 residents (R38, R45, R46, R47) reviewed with concerns related to staff knocking on room doors. Findings include:	F 583	Bywood East Health Care continues to ensure that the privacy of all residents is respected at all times. All staff will review customer service that included: knocking, calling out or knocking again before entering the residents room June 26 and repeated June 28.	

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F 583	Continued From page 9 R38's quarterly Minimum Data Set (MDS) dated 3/25/18, indicated resident was moderately cognitively impaired, had moderately severe depression and was able to hear and communicate without difficulty. During interview on 5/20/18, at 12:58 p.m. R38 stated sometimes the staff just "barge in" without knocking. During observation on 5/22/18, at 8:05 a.m. nursing assistant (NA)-B knocked on R38's door. Without waiting for an answer, NA-B entered the room. R45's quarterly MDS dated 4/3/18, indicated resident was moderately cognitively impaired, had minimal depression and was able to hear and communicate without difficulty. During observation on 5/22/18, at 7:29 a.m. NA-B entered R45's room without knocking. At 8:04 a.m. NA-B knocked on R45's door and immediately entered without waiting for a response. During interview on 5/22/18, at 1:49 p.m. R45 stated she wished staff would knock on the door and wait for her or someone to respond. R45 stated it happened often and she liked her privacy. R46's annual MDS dated 4/3/18, indicated resident was cognitively intact, had minimal depression and was able to hear and communicate without difficulty.	F 583	A customer service audit was completed and reviewed with staff. The interdisciplinary team will audit weekly for four weeks, monthly for two months and then as needed. Audits will be reviewed in morning stand up with re-education as needed. Continued compliance will be the responsibility of the Administrator, staff development nurse and interdisciplinary team. Compliance will be presented to QAPI quarterly in July and October 2018 then ongoing as needed.	

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F 583	Continued From page 10 During observation on 5/22/18, at 7:48 a.m. NA-C knocked on the door to R46's room and entered without waiting for a response. During interview on 5/22/18, at 2:00 p.m. R46 stated she would like staff to knock and wait until she answered and stated it was her room. R46 stated some staff do knock and wait, but many do not. R47's quarterly MDS dated 4/3/18, indicated resident was cognitively intact, had minimal depression and was able to hear and communicate without difficulty. During observation on 5/22/18, at 7:48 a.m. NA-C knocked on R47's door and entered without waiting for a response. During interview on 5/22/18, at 2:05 pm. R47 stated she would like staff to knock and wait a minute or two. R47 stated it made her uncomfortable when staff just enter. During interview on 5/22/18, at 8:05 a.m. NA-B stated staff were instructed to knock on the residents doors and wait for them to respond. NA-B stated some of the residents can respond, but some could not. She verified the rooms she entered during the observation were rooms in which the residents couldn ' t respond and stated, it was not ok to enter without knocking. During interview on 5/22/18, at 8:25 a.m. NA-C stated staff were instructed to knock on residents doors and ask if they could come in. NA-C stated she knew the routines of the residents so she knew they were sleeping therefore would knock and walk right in and check on them. NA-C	F 583		

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F 583	Continued From page 11 verified she had walked into residents rooms without awaiting a response and stated it was okay to walk in a room if she knew they were sleeping. On 5/22/18, at 8:30 a.m. registered nurse (RN)-C stated staff are to knock and wait for an answer. She stated if the resident does not answer they should announce themselves as the enter. RN-C stated even if the staff believe the resident is asleep they should still knock and wait for a response. On 5/22/18, at 10:00 a.m. the director of nursing stated staff should knock, wait and knock again with the exception of a comatose or deaf resident or if they knew none of the residents were in the room. The DON stated there was no facility policy related to knocking on doors but stated a customer service training had been completed. Policy and Procedure for Provision of Resident Personal Privacy dated 9/2011 instructed staff, "All personnel will knock on resident doors and wait for a response, if appropriate, before entering the room."	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		7/2/18

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

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F 584	Continued From page 12 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 ℉; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide an environment in a sanitary manner for 1 of 2 residents (R24). In addition failed to keep furniture in good repair to maintain cleanable surfaces.	F 584	The privacy curtains were removed and replaced with clean privacy curtains on 5/22/18. The deep cleaning room checklist will be reviewed with the housekeeping staff on June 20 to remind them to check privacy	

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F 584	Continued From page 13 Findings include: R24's quarterly Minimum Data Set (MDS) dated 3/6/18, indicated R24 had moderately impaired cognition and required limited to extensive physical assistance of one staff with activities of daily living. On 5/20/18, at 6:03 p.m. when asked if the room was clean, R24 reached out to the privacy curtain in front of him by the television and multiple visible red brown stains were observed. R24 stated he did not even know what all those stains were. On 5/21/18, at 9:00 a.m. to 11:00 a.m. the privacy curtain was observed pulled all the way around R24's bed and the stains remained visible when entering R24's space. On 5/22/18, from 9:55 a.m. to 10:03 a.m. the environmental tour was completed with the facility administrator and the director of maintenance and environmental services. During the tour the administrator verified the privacy curtain was soiled. When asked who was responsible for making sure the curtains were maintained clean and in a sanitary manner she stated housekeeping was supposed to let maintenance know to remove them to get washed when deep cleaning was being done to the room. On 5/23/18, at 9:31 a.m. a metal frame chair with a pink seat was observed in the second for lounge. The chair had three holes in it exposing the fabric under the covering. A second wood framed chair had seven holes in the seat cover.	F 584	curtains and remove when soiled. The facility is currently going through a complete interior redecorating project. The chairs were removed from the dayroom lounge on May 23 and replaced with chairs that were clean and intact. New chairs will be ordered as part of the redecorating project in late June. All staff will be reminded of the Repair Request procedure at the All Staff meeting on June 26 and 28. To monitor, the Maintenance Director or designee will round weekly to ensure that the building is kept in a safe and clean environment.	

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F 584	Continued From page 14 At 9:33 a.m. housekeeper-A was shown the chairs and was asked how the chairs would be cleaned. Housekeeper-A stated the chairs were wiped off with a sanitizing solution. When asked about being able to sanitize them with the holes in the chair, housekeeper-A stated the chairs could not be sanitized. When asked what the procedure was when furniture or equipment was broken, Housekeeper-A stated she would report it to the maintenance director. During interview at 10:13 a.m the maintenance director (MD) stated the chairs needed to be replaced. When asked what would be done in the meantime, MD stated "I don't suppose I can cover them with duct tape." When asked about a log or the system for reporting furniture the MD stated he was not aware if there was a log or system, but would get the information. At 11:34 AM MD reported the chairs were removed from the second floor lounge and explained when there was furniture or equipment needing repair or removal the staff filled out a maintenance request. Those requests were given to the maintenance staff. MD added there was no log for tracking maintenance requests, but stated when the maintenance staff completed the task the request was signed off on and placed in a completion file. On 2/23/18, at 2:00 p.m. during interview, the Administrator stated the facility did not have a policy or procedure related to reporting when furniture or equipment needed repair or replacement, but the staff were told at orientation what the process was and how to fill out the maintenance request slip.	F 584		

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F 609	Continued From page 15	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 report allegations of abuse to the state agency (SA) for 1 of 3 residents (R74) reviewed for abuse. Findings include:	F 609	R74 no longer resides in the facility. The incident policy was reviewed with the interdisciplinary staff. The incident report form was reviewed and adapted for better use during non-fall incidents. Incident reports are discussed Monday thru Friday	7/2/18

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F 609	Continued From page 16 R74's quarterly Minimum Data Set (MDS) dated 5/10/18, indicated he was cognitively intact, independent with daily decision making and displayed only verbal behavioral symptoms toward others. R74's care plan dated 11/17/17,revealed resident had areas of vulnerability due to cognitive deficits and inaccessibility to family members. Identified goals included: resident will have minimized risk of abuse. R74's care plan instructed staff to remove resident from the aggressor and relocate to a safe location, observe and provide a safe environment and report vulnerable adults to the state agency according to policy. A review of Resident Incident Reports identified the following: 12/11/17, indicated R74 reported to staff roommate R5 was aggressive toward him. R74 stated he did not want to wake up with a knife to his throat. Staff instructed R5 to stay away from R74. Interdisciplinary team (IDT) comments dated 12/13/17, on Resident Incident Report indicated offered different room, put on list well checks alcohol behavior. Resident Incident Report section on potential vulnerable adult issue was blank. 2/22/18, indicated R74 was struck by R5 with a closed fist when R74 told R5 not to touch a staff member. IDT comments dated 2/23/18, on Resident Incident Report indicated offered different room, resident refused assist with calling police if needed. Resident Incident Report section on potential vulnerable adult issue was blank.	F 609	at morning stand up and PRN on the weekend. The facility continues to report and investigate all concerns expressed by residents, staff or visitors. The Interdisciplinary Team reviewed all policies involving abuse, neglect and mistreatment. The facility current procedure for notifying and reporting was reviewed with the Interdisciplinary Team and Licensed staff. Director of social services or designee and Director of Nurses or designee will review the incident reports for missed reports. During the review the incident report section on potential vulnerable adult issues will be checked for completion. Continued compliance will be the responsibility of the director of nursing and the director of social services, or designee. The data will be presented to QAPI in July and October and then ongoing as needed.	

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F 609	Continued From page 17 4/15/18, indicated R74 reported to staff, his side really hurt and said, "I don't need to put up with this pain." R74 showed staff two purple bruises under his left breast approximately two centimeters in diameter. When asked how he got the bruises R74 said, "My Room mate." IDT comments dated 4/23/18, on Resident Incident Report indicated monitor bruises until healed. Resident Incident Report section on potential vulnerable adult issue was blank. 4/24/18, at 1:30 p.m. indicated R74 made repeated verbal threats toward staff. Police were called and spoke with R74. a second Resident Incident Report at 8:20 p.m. indicated staff witnessed R48 run toward R74 yelling at him to leave. R48 then shoved R74 against the wall causing him to slip and nearly fall. Back of Resident Incident Report blank. Suspected Substance Abuse form attached to the Resident Incident Reports and indicated R74 admitted to having a few drinks. All forms were attached to each other. IDT comments dated 4/25/18, on Resident Incident Report dated 4/24/18, at 1:30 p.m. indicated, "30 day notice, 911 hospital Left AMA[against medical advice], came to facility & [and] left gain 2 [secondary to] police escort." signed by the DON Resident Incident Report section on potential vulnerable adult issue was blank. During interview on 5/23/18, at 2:06 p.m. the director of nursing (DON) stated the incident on 2/22/18, was not reported to the SA but was reported to the police. She stated she did not believe R5 wanted to hurt R74 and was being protective of the staff. Regarding an investigations, the DON stated she only had the incident report and the nurses notes. In regard to	F 609		

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F 609	Continued From page 18 the incident on 4/15/18, the DON indicated R74's bruising was related to a medical diagnosis that affected his clotting time and stated, he had bruises. She stated she did not have an investigation in front of her at the time, but was sure one was done. In regards to the incident on 4/24/18 of R74 being shoved into the wall by R48 the DON stated she had never seen that R74 had been shoved on that until reviewing incident reports with surveyor. DON stated the incident of R48 shoving R74 into the wall should have been reported. The DON stated there was no additional investigation but the information that was on the Resident Incident Reports. the DON stated if the incidents had been reported, a more detailed investigation would have been completed. A facility policy titled Vulnerable Adult Abuse Prevention Policy dated 2/1/17, indicated the facility does not tolerate any forms of abuse. The policy defined physical abuse as, but not limited to hitting, kicking, slapping and punching. Initial notification to the SA will be completed immediately following evaluation of the incident involving suspected abuse or mistreatment.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		7/2/18

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F 610	Continued From page 19 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 thoroughly investigate allegations of abuse for 1 of 3 residents (R74) reviewed for abuse. Findings include: A facility policy titled Vulnerable Adult Abuse Prevention Policy dated 2/1/17, indicated the facility does not tolerate any forms of abuse. Upon receiving a report of an incident, the resident will be assessed and an investigation inititate. The investigation shall include interviews of the ivolved resident, family members, interdisciplinary team and any others who may have information about the event. R74's quarterly Minimum Data Set (MDS) dated 5/10/18, indicated he was cognitively intact, independent with daily decision making and displayed only verbal behavioral symptoms toward others. R74's care plan dated 11/17/17,revealed resident had areas of vulnerability due to cognitive deficits and inaccessibility to family members. Identified goals included: resident will have minimized risk of abuse. R74's care plan instructed staff to remove resident from the aggressor and relocate	F 610	R74 no longer resides in the facility. The incident policy was reviewed with all staff. The incident report form was reviewed and adapted for better use during non-fall incidents. Incident reports are discussed Monday thru Friday at morning stand up and PRN on the weekend. Documentation of actions, interviews and additional data will be completed on the Incident Reports to support changes to care plans, facility policy or location of residents. The facility continues to report and investigate all concerns expressed by residents, staff or visitors. The Interdisciplinary Team reviewed all policies involving abuse, neglect and mistreatment. The facility current procedure for notifying and reporting was reviewed with the Interdisciplinary Team and Licensed staff. Director of social services or designee and Director of Nurses or designee will review the incident reports for missed reports. During the review the incident report section on potential vulnerable adult issues will be checked for completion.	

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F 610	Continued From page 20 to a safe location, observe and provide a safe environment and report vulnerable adults to the state agency according to policy. A review of Resident Incident Reports identified the following: 12/11/17, indicated R74 reported to staff roommate R5 was aggressive toward him. R74 stated he did not want to wake up with a knife to his throat. Staff instructed R5 to stay away from R74. Interdisciplinary team (IDT) comments dated 12/13/17, on Resident Incident Report indicated offered different room, put on list well checks alcohol behavior. Resident Incident Report section on potential vulnerable adult issue was blank. The record lacked evidence of an investigation following the incident. 2/22/18, indicated R74 was struck by R5 with a closed fist when R74 told R5 not to touch a staff member. IDT comments dated 2/23/18, on Resident Incident Report indicated offered different room, resident refused assist with calling police if needed. Resident Incident Report section on potential vulnerable adult issue was blank.The record lacked evidence of an investigation following the incident. 4/15/18, indicated R74 reported to staff, his side really hurt and said, "I don't need to put up with this pain." R74 showed staff two purple bruises under his left breast approximately two centimeters in diameter. When asked how he got the bruises R74 said, "My Room mate." IDT comments dated 4/23/18, on Resident Incident Report indicated monitor bruises until healed. Resident Incident Report section on potential vulnerable adult issue was blank. The record	F 610	The Director of Nursing and the Director of Social Service will monitor. The data will be presented to QAPI in July and October, then ongoing as needed.	

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F 610	Continued From page 21	F 610		

lacked evidence of an investigation following the incident.

4/24/18, at 1:30 p.m. indicated R74 made verbal threats toward staff. Police were called and spoke with R74. a second Resident Incident Report at 8:20 p.m. indicated staff witnessed R48 run toward R74 yelling at him to leave. R48 then shoved R74 against the wall causing him to slip and nearly fall. Back of Resident Incident Report blank. Suspected Substance Abuse form attached to the Resident Incident Reports and indicated R74 admitted to having a few drinks. All forms were attached to each other. IDT comments dated 4/25/18, on Resident Incident Report dated 4/24/18, at 1:30 p.m. indicated, "30 day notice, 911 hospital Left AMA[against medical advice], came to facility & [and] left gain 2 [secondary to] police escort." signed by the DON Resident Incident Report section on potential vulnerable adult issue was blank. The record lacked evidence of an investigation following the incident.

During interview on 5/23/18, at 2:06 p.m. the director of nursing (DON) stated the incident on 2/22/18, was not reported to the SA but was reported to the police. The DON stated, looking back, she did not know why a report was not made to the SA. She stated she did not believe R5 wanted to hurt R74 and was being protective of the staff. In regard to the incident on 4/15/18, the DON stated it was not reported to the SA because the bruises were not injuries of unknown origin. She stated the interdisciplinary team met and discussed the incident and determined it was not reportable. She indicated R74's bruising was related to a medical diagnosis that affected his clotting time and stated, he had bruises. In

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F 610	Continued From page 22 regards to the incident on 4/24/18 of R74 being shoved into the wall by R48 the DON stated she had never seen that R74 had been shoved on that until reviewing incident reports with surveyor. DON stated the incident of R48 shoving R74 into the wall should have been reported. The DON stated there was no additional investigation but the information that was on the Resident Incident Reports. the DON stated if the incidents had been reported, a more detailed investigation would have been completed.	F 610		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		7/2/18

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F 625	Continued From page 23 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 7 residents (R23, R45, R17, R28) or legal representatives had been informed of bed hold rights at the time of hospitalizations. Findings include: R23's admission Minimum Data Set (MDS) dated 3/12/18, indicated R23 had intact cognition. On 5/20/18, at 7:07 p.m. R23 stated she had gone to the hospital recently. When asked weather the facility had told her about holding her bed, R23 stated she did not see anything with this last hospitalization. During review of the medical record, it was revealed R23 had gone to a routine appointment and had been admitted to the hospital on 1/25/18. During further review of the medical record it was revealed R23 had been re-admitted back to the facility on 2/28/18, as a new admission. The Progress notes lacked documentation indicating a bed hold notice had been sent to the hospital or had been discussed with R23 during the hospital stay. In addition, the medical record lacked documentation of the facility notifying the regional ombudsman of the discharge from the facility after 18 days. On 5/21/18, at 4:13 p.m. the medical record representative (MRR) stated R23 had gone to an	F 625	Staff review of Bed Hold policy and procedure was completed. Bed Hold forms have been placed on each floor to encourage compliance Nursing staff will be instructed on the policy and procedure by June 25, 2018 Bed Hold Policy will be provided upon admission to the facility and sent with each resident or provide to their legal representative if the resident transfers out or goes on therapeutic leave. The medical records designee will review all transfers for bed hold and update the administrator or director of social services of noncompliance. Continued compliance will be the responsibility of the administrator, director of social services, or designee. The data will be presented to QAPI July and October, then ongoing quarterly as needed.	

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F 625	Continued From page 24	F 625		

appointment and they admitted her right after the appointment. The MRR stated R23 was admitted to the hospital on 1/25/18, and was discharged from the facility on 2/12/18 when the 18 day bed hold expired and R23 had been admitted to the facility as a new admission on 2/28/18. When asked if R23 or her representative had been informed of the bed hold notice, MRR stated there had been a change in the department personnel and she was not sure if this had been discussed. The MRR verified a bed hold notice had not been provided or discussed with R23 "I have no proof." The MRR further stated R23 had kept calling the facility multiple time during the hospital stay to let staff know she was going to come back but the bed hold notice had never been discussed.

On 5/21/18, at 4:28 p.m. when asked when bed hold notices were provided licensed practical nurse (LPN)-B stated "we are supposed to fill the form and give to the residents however at times when we called the ambulance sometimes it was not possible to give the notice and that time we would keep the form and have the resident sign it at the time they return to the facility from the hospital stay." When asked if the form was faxed to the hospital LPN-A stated "I was not told that. Sometimes the hospital would call the facility and ask if the facility was holding the bed for the resident upon return."

R45 diagnoses included anxiety and depression, alcohol abuse, schizophrenia, chronic kidney disease and psychosis obtained from the Admission Record dated 5/23/18. In addition the Admission Record indicated R45 was not her own responsible party.

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F 625	Continued From page 25 Review of the MDS's indicated R45 had been hospitalized multiple times on the following dates: - 3/10/18, to 3/13/18, R45 was sent out due to increased behaviors - 3/24/18, to 4/1/18, R45 was sent out due to vomiting episodes of undigested food which was mocha pink colored - 5/14/18 to 5/17/18, R45 was sent out due to increased behaviors and staff was unable to redirected her. Review of the interdisciplinary notes lacked evidence of the facility providing or attempting to inform R45 or the responsible representative of the bed hold during all three hospital transfers. In addition, the medical record lacked documentation the regional ombudsman had been informed of the facility initiated transfers to an acute care facility. On 5/21/18, at 9:51 a.m. the MRR stated she was only able to find one bed hold notice which had been provided to R45 on 2/17/18, with a return to facility on 2/18/18, when R45 had gone on a leave of absence. The MRR further stated "you have taught me to be more alert on making sure they are done." On 5/21/18, at 3:00 p.m. the director of social services stated nursing was supposed to provide all the bed hold notices to residents each time they went out of the facility to the hospital or a leave of absence.	F 625		

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F 625	Continued From page 26 R17's Admission Record dated 5/23/18, included diagnoses of alcohol induced dementia, anxiety, osteoarthritis and depression. R17's Annual minimum data set (MDS) dated 2/27/18, indicated R17 had moderate cognitive impairment and required extensive assistance with all activities of daily living. R17's electronic Resident Census List identified the following hospitalizations: -3/13/18 hospital leave, with a 3/15/18 return to the facility. -5/13/18 hospital leave, with a 5/15/18 return to the facility. -5/18/18 hospital leave, with a 5/19/18 return to the facility. Review of R17's medical record included a Bywood East Health Care Resident Bed Hold Policy dated 3/13/18 which indicated R17 was to return on Thursday 3/15/18, but was not signed by the resident/representative. Review of Bywood East Health Care Resident Bed Hold Policy dated 5/13/18, was not received nor signed by resident/representative. There was no Bywood East Health Care Resident Bed Hold Policy provided to the resident for the 5/18/18 hospitalization. During interview on 5/20/18, at 2:45 p.m. R17 stated she had pneumonia and went to the hospital. When asked if a bed hold notice had been provided to her, she stated she did not know what the surveyor was talking about and did not think so. During interview on 5/21/18, at 9:51 a.m. the	F 625		

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F 625	Continued From page 27 MRR provided Resident Bed Hold Policies for 3/13/18 and 5/13/18. MRR stated "you would have thought I would have been more alert on making sure they are done." During interview on 5/23/18, at 8:23 a.m. MRR was asked who is responsible to give the bed hold notification to residents/representatives. MRR stated "well, it's a group effort, nurses are supposed to give them, but as of today, I will be checking to make sure they did." MRR verfied there were no bed hold notices given for May. R28's quarterly Minimum Data Set (MDS) dated 3/13/18, indicated R28 had intact cognition. R28's Progress Note dated 1/30/18, indicted R28 had been admitted to the hospital with a urinary tract infection. During further review of the medical record it was revealed R28 had been re-admitted back to the facility on 2/2/18. The Progress Notes lacked documentation indicating a bed hold notice had been sent to the hospital or had been discussed with R28 during the hospital stay.	F 625		

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F 625	Continued From page 28 On 5/21/18, at 2:47 p.m., R28 stated no one sent a bed hold policy to the hospital, or discussed it upon return.. R28 stated bed hold policy had been explained at time of admission. On 5/21/18, at 2:54 p.m., the medical record representative (MRR) stated R28 had admitted to the hospital from a leave of absence. When asked if R28 or representative had been informed of the bed hold notice, MRR stated there was no evidence it had been done. On 5/23/18, at 2:06 p.m., the director of nurses (DON) stated facility had not been at census in a very long time, so facility did not get paid for bed holds. DON stated residents could be out as a long as they needed. DON stated medical records was to ensure a bed hold was given to residents or resident representative. DON stated Ombudsman notification was only done for residents who actually discharged and were not readmitted.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) to indicate side rails were not used as a restraint for 1 of 1 resident (R24) reviewed for resident assessment. Findings include:	F 641	The facility continues to strive for accurate MDS coding. R24□s MDS□s have been corrected. Audit of all residents with mobility devices has been completed with no concerns noted.	7/2/18

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F 641	Continued From page 29 R24's diagnoses included hemiplegia, dementia degenerative disease of nervous system, age-related cataract and age-related osteoporosis obtained from the May 2018 Medication Administration Record. R24's quarterly MDS dated 3/6/18, indicated moderately impaired cognition. R24's mobility care plan dated 3/5/18, indicated he was unsteady with transitions from a seated to standing position and ambulation and required staff assistance to stabilize. The care plan indicated R24 had a mobility device on his bed per physician orders. On 5/22/18, at 8:38 a.m. when approached and asked about the mobility device R24 stated he used it to get in and out of the bed and it did not restrict him. R24 stated he was able to get in and out of bed independently. At the time the wheelchair was parked right next to the bed and the mobility bar was on R24's left hand side. On 5/22/18, at 8:05 a.m. registered nurse (RN)-A reviewed R24's quarterly MDS dated 3/6/18, and verified the MDS had been coded to indicate R24 used a bed rail daily as a restraint. RN-A stated "That is how I have always done it because it is a mobility device and it is a fixed device to the bed." Surveyor reviewed the Resident Assessment Instrument (RAI) restraint definition with RN-A and she acknowledged the MDS had been coded inaccurately and stated she was going to modify it. Surveyor reviewed the mobility device assessment dated 3/6/18, and RN-A verified the assessment had not indicated the mobility device was a restraint. At 8:49 a.m. RN-A approached stated she had corrected the last two MDS's for	F 641	MDS Nurse has reviewed Resident Assessment Instrument, for definition of restraints. The facility Mobility Device Policy and Procedure was reviewed by nursing management The Director of Nurses or designee will audit all MDS□s monthly for restraints for errors using Point Click Care electronic medical record. Continued compliance will be the responsibility of the Administrator, MDS nurse, or designee. The data will be presented at QAPI in July and October, then ongoing quarterly if needed.	

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F 641	Continued From page 30 R24 and she did not know why she had coded the MDS's for the restraint use. On 5/22/18, at 9:17 a.m. the director of nursing stated she would expect MDS's to be coded accurately. CMS's (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, version 1.15R dated October 2017, indicated, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."	F 641		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to document staging and characteristics of wound(s) for 1 of 1 resident	F 686	R15□s wound has resolved. Licensed staff have reviewed the systems for staging, documentation and ongoing	7/2/18

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F 686	Continued From page 31 (R15) reviewed for pressure ulcers. Findings include: During interview on 5/20/18, at 4:54 p.m. R15 stated he had open sores, one on each buttock and has had them for "two to three months." R15 was observed on 5/22/18, at 8:02 a.m. sitting in his wheelchair on a cushion that had back and bottom support. R15 stated last year "Courage Kenny" came out and fit it for him. During observation on 5/22/18, at 2:32 p.m. with the director of nursing (DON) and nursing assistant (NA-D) a Stage II pressure ulcer was observed on the right buttock to be round, approximately 1 centimeter (cm) in diameter. Three other healed areas were noted. R15 was admitted on 12/11/07, and had diagnoses that included schizophrenia, demyelinating disease of the central nervous system, peripheral vascular disease and an ileostomy, obtained from the Resident Face Sheet dated 5/23/18. The Care Area Assessment dated 11/21/17, indicated R15 was at risk for developing pressure areas due to immobility, altered mental status and recent hospitalization. The Quarterly Minimum Data Set dated 2/20/18, indicated R15 had intact cognition, was non-ambulatory and required extensive assistance with bed mobility and transfers and total dependence for toileting. The Individual Resident Care Plan with revision date 11/29/17, indicated R15 was able to voice his needs, was at risk for skin	F 686	monitoring of the facility skin concerns. A skin flowsheet was developed to monitor healing of all pressure and non- pressure wounds. Braden□s scores have been reviewed with audit of care plan and status of resident□s skin completed for any resident who scored 14-18. Direct care staff have reviewed the bath day audit for accurate charting and need for immediate reporting of wounds. Bath Sheets will be cosigned by nurse and audited by nursing management for follow up as needed. The Director of Nurses or designee will audit all wound documentation weekly for four weeks then monthly for two months. Wounds will be monitored weekly and as needed by clinical staff should they occur. Continued compliance will be the responsibility of the Director of Nursing, the Staff Development nurse and MDS nurse, or designee. The data will be presented to QAPI in July and October and then ongoing as needed.	

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F 686	Continued From page 32	F 686		

breakdown/pressure ulcers, "but skin remains intact." The care plan outlined interventions of following facility protocol/regime for treating breaks in skin integrity/pressure ulcer (PU) and have chair cushion on wheelchair. On 4/12/18, the care plan was revised to indicate R15 had "potential for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: non-compliance with therapeutic regime and moisture as noted by folds" and to ensure special cushion is in place on wheelchair everyday, follow facility protocol/regime for treating breaks in skin integrity/pressure ulcers and document on flow sheet if skin was intact.

The Braden Scale for Predicting Pressure Sore Risk dated 5/22/18, indicated a score of 15 and on 5/10/18 the Braden score was 18 (score of 15-18 indicates the resident was at risk). Review of a Quarterly Nutritional Assessment dated 5/22/18 indicated R15 did not walk with staff and that the yogurt at breakfast and cottage cheese at lunch would be discontinued as "skin healed/intact."

Review of the nurse practitioner (NP) progress note dated 4/12/18, indicated R15 was seen for follow up on pressure ulcers on both legs and that staff reported he had not been using the cushion on his wheelchair. The report indicated the left posterior thigh had a stage I PU measuring 0.5 centimeter (cm) X 0.5 cm in diameter and the right posterior leg had a stage II PU, reported as measuring 1.0 cm X 0.8 cm.

Review of the Medication Administration Record (MAR) dated April 12 - 30, 2018 directed staff to clean open areas, apply barrier cream to open

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F 686	Continued From page 33 areas every shift and check placement of wheelchair cushion every shift. Review of the MAR dated May 2018, indicated to apply barrier cream with zinc to bottom every shift and did not indicate to clean open areas and apply barrier cream to open areas every shift. Review of Bath and Skin Reports for April 2018 indicated the following: - 4/3/18: assisted with full shower and no skin issues. I apply lotion on his hands and feet. - 4/6/18: assisted him with shower and no skin issues. - 4/10/18: assisted with full shower and no skin issues. I put lotion. - 4/12/18: had full shower and got pressure sore on right of butt. Notified nurse. - 4/20/18: assisted with full shower and no skin issues. I put pink cream ointment at back of open sore. - 4/24/18: assisted him for full shower and no skin issues but one small sore on his back of right butt and I put pink ointment. - 4/27/18: assisted him with full body shower and got bruise on his left leg. Informed the nurse on floor. - 5/1/18: had full shower and no skin issue. - 5/4/18: assisted with full shower and no new skin issues. - 5/11/18: no skin problem. - 5/16/18: assisted him with full body shower. No skin issues. - 5/18/18: assisted with full shower and no skin issues. - 5/22/18: assisted him with full body shower. Rashes near his private part. Put some powder and notify to the nurse.	F 686		

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F 686	Continued From page 34	F 686		

Review of Progress Notes indicated:

- 4/12/18 "non-blanchable area on inner aspect of skin below gluteus, 0.5 cm X 0.5 cm on left leg, consistent with Stage 1 decubitus. Writer also observed a red non-blanchable area with first layer of skin removed on inner aspect of skin below the gluteus of 1 cm X 0.8 cm on right leg. This is consistent with a Stage 2 decubitus. Both areas are consistent with placement of legs against wheelchair. Writer to update physician and dietary. Facility skin assessment including wound measurement and Braden assessment to be performed weekly, further notice. Resident will be encouraged to offload from wheelchair between meals and wheelchair to be checked for cushion daily."

- 4/17/18 "Res [resident] stood allowing writer to visualize legs, skin WNL [within normal limits] denied pain and no sign of open area. Staff continues to apply skin protectant, resident again removed w/c [wheelchair] cushion and states it fall out. Will place dycem [non slip material for improving grip] between w/c and cushion."

- 4/17/18 "skin integrity continue to be monitored with no new signs of infection, no opening areas noted, did not take the cushion from the chair during this shift"

- 5/22/18 Dietary note "skin is intact. Will d/c [discontinue] yogurt at breakfast and cottage cheese at lunch."

- 5/22/18 at 3:40 p.m. "resident has superficial open area below the right buttock that measures 1 cm by 1 cm r/t [related to] moisture. barrier

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F 686	Continued From page 35 cream applied, offloading every hour as resident allows and encouraged and checking that cushion is in place" During interview on 5/22/18, at 9:06 a.m. NA-A stated both buttocks had small sores, "but they are healing, we put cream on them." During interview on 5/22/18, at 9:17 a.m. the DON stated there were no open areas anymore, "I think they are all healed, he is using his cushion now for about the last month or so and not putting it in his closet." During interview on 5/22/18, at 12:49 p.m. surveyor requested to see R15's bottom at which time the DON stated he had an open area and would see where R15 was and "how wound up he is." During interview on 5/22/18, at 1:29 p.m. the DON stated the nurse completes skin assessment on admit, after hospitalization and that the NA's conduct the body audits. The DON further stated that nurses do not perform a weekly body audit on everyone, "I review the Braden for changes and if below 14 we look a little closer." During interview on 5/22/18, at 1:40 p.m. NA-C stated they give R15 a shower, look at the skin and that R15 had a bad sore on his bottom for a long time, "oh, at least a couple of months." NA-C stated it had been reported to the nurse since it had been there. During interview on 5/22/18, at 2:36 p.m. the DON stated she thought the area was moisture related, didn't believe it was pressure related, "we	F 686		

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F 686	Continued From page 36 don't stage it." The DON further stated she didn't know when it appeared, "I was the nurse on the floor two weeks ago and it wasn't there." At 2:42 p.m. the DON returned and stated the wound was 1.5 cm X 1.5 cm. During interview on 5/23/18, at 9:20 a.m. R15 stated he will switch positions to "get off my sores", and that staff had not checked them for at least a couple weeks. R15 further stated "I have a cushion, since they put the sticky stuff on it, it works." During interview on 5/23/18, at 10:02 a.m. registered nurse (RN-A) stated she does not do a skin assessment, does complete a Braden Score, so doesn't do a visual inspection, "that usually happens with showers." During interview on 5/23/18, at 3:10 p.m. the DON stated they do not have a PU policy and procedure "because we have never had a pressure ulcer before", we do a Braden, nutrition and have instructions on the MAR. Review of the facility Nutritional Intervention of Open Areas and Pressure Ulcers Policy and Procedure dated 5/2002, indicated that nutritional interventions will begin immediately following notification of a newly diagnosed open area or pressure ulcer. The resident would be added to the list of "High Nutritional Risk" residents and monitored monthly until the open area or pressure ulcer is healed.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		7/2/18

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F 689	Continued From page 37 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)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 ensure safe smoking practices for 1 of 3 residents (R34) reviewed for smoking. Findings include: R34's quarterly minimum data set (MDS) dated 3/22/18, indicated he had intact cognition, was independent with activities of daily living and had no upper or lower extremity impairment. R34's care plan dated 4/16/18, indicated independence with smoking and directed staff to update social services if burns on skin or clothing. The care plan further indicated R34's fingernails were dirty with tar from cigarette smoking. A Smoking Safety Evaluation dated 5/11/18, indicated R34 smoked only in designated areas, lit smoking materials safely, responded to fallen ashes and had no history of injuries secondary to smoking. The assessment indicated he could smoke safely un-supervised. The evaluation indicated R34's clothing did not have burn holes at the time of admission. Review of R34's Progress Notes identified the following behaviors related to smoking. 1/23/18, R34 entered the smoking room and	F 689	R34□s smoking evaluation has been reviewed with changes as required. Review of the smoking policy was completed by staff. Licensed and direct care staff have reviewed the rules related to smoking, smoke room use and resident clothing condition. The Social Services Director and designee have reviewed the intent and use of the smoking assessment and documented each resident□s preference related to clothing with burns. As needed the Social Work director and designee will assist the resident in locating replacement clothing. The laundry staff will be informed of their responsibilities regarding clothing damaged with cigarette burns on June 20, 2018. All Staff will be trained on the smoking policies at All Staff meetings on June 26 and 28, 2018. The Director of Social Services or designee will audit all Smoking Assessments with each MDS and PRN if	

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F 689	Continued From page 38 checked the ashtrays for cigarette butts. Writer spoke to him regarding the need to have a cigarette when he entered the room. R34 told writer he had a cigarette in his pocket. Later R34 was rolling a cigarette in the smoke room. He was told he was not allowed to do that. 5/20/18, R34 entered the smoke room and took a cigarette butt from his pocket and was about to light it. Writer told him not to do so and R34 threw the butt away and took another longer butt from his pocket. During observation on 5/21/18, at 8:23 a.m. R34 was outside smoking on the back patio of the facility. R24 was holding a cigarette in his left hand. His hand was shaking back and forth. He was wearing a fleece jacket with burn holes and sweat pants that had burn holes. R34 dropped an ash on his jacket and wiped it away with his left hand. R34's left hand was stained brown from tobacco. He had a black area on his right forefinger and the inside of his middle finger and 4 small white blister like areas on the web between his thumb and forefinger. R34 stated he liked to put his cigarette butts in his pocket and smoke them later. On 5/22/18, at 9:20 a.m. R34 was in the facility smoking room. He had a cigarette in his left hand and his head was down. His cigarette had an ash approximately a half inch long. At 9:22 a.m. R34 remained with his head down and appeared to be sleeping, the cigarette still burning. At 9:24 a.m. he put his head up and ashed his cigarette. At 9:26 a.m. another resident exited the smoking room and stated R34 had fallen asleep. During interview on 5/22/18, at 1:20 p.m. social	F 689	needed. Continued compliance will be the responsibility of the administration, social services director, or designee. The data will be presented to QAPI July and October and then ongoing as needed.	

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F 689	Continued From page 39	F 689		

services designee (SSD) stated upon admission she completed a smoking assessment. SSD stated she watched the residents smoke and checked the clothing for burn holes. She stated if they smoke safely and have no burn holes she determined them to be safe to smoke without supervision. She stated if staff reported burn holes she would complete another assessment. SSD stated no one had ever reported burn holes in R34's clothes.

At 1:27 p.m. the director of social services (DSS) stated, "I think he came in with some clothes that had burn holes in them." The DSS stated she had noticed a jacket with some burn holes. She further stated she thought the back areas on R34's fingers were from the cigarettes.

At 1:29 p.m. the director of nursing (DON) stated she felt the black areas on R34's fingers were due to staining. She stated she did not think he was burning himself. When asked about a skin assessment, the DON stated she did not think there was a skin assessment that identified the areas on his fingers. She stated a licensed nurse completed a skin assessment on admission and after hospitalization. The DON stated the nursing assistants completed the weekly body audit and the nurses reviewed for changes. At 1:37 p.m. the DON stated there was nothing in R34's record that identified the discoloration to his fingers nor was there an inventory of R34's clothing that identified the presence of burn holes on admission.

During interview on 5/23/18, at 10:02 a.m. registered nurse (RN)-A identified herself as the MDS coordinator. RN-A stated she did not complete a skin assessment when completing the

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F 689	Continued From page 40 MDS assessments and stated skin inspections were completed by the nursing assistants weekly during showers. RN-A stated if a resident came back from the hospital a nurse would complete a skin assessment. She stated she was not aware of any alterations is R34's skin except for some areas on his hands that she described as "tar-ish." She stated she was not aware of any assessment completed related to the blackened areas of R34's fingers. At 10:07 a.m. RN-A approached R34 and looked at his fingers. She stated the black areas looked like they may have been from a burn or a callous. She stated the white spots were "hard to tell" if they were burns. A facility policy titled Bywood East Healthcare, Skin Condition Assessment and Treatment dated 10/2012, directed staff to document in the care plan skin conditions that are risk factors for a more serious problems, to include abrasion, bruises and burns. A facility policy titled Bywood East Health Care Smoking Policy and Procedure dated 4/18, indicated the safety of our facility supercedes the individuals resident's right to smoke unsafely.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		7/2/18

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F 755	Continued From page 41 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify when insulin was opened and/or identify when the insulin would expire, resulting in administration of expired insulin, for 4 of 14 residents (R26, R57, R70, R1) who were administered insulin. Findings include: R26's Medication Administration Record (MAR) for May 2018, identified R26 received Novolog (a fast acting insulin used to reduce blood sugar levels) three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Novolog insulin for	F 755	Review of finger stick blood glucose for R26, R57, R70 and R1. Medication Error reports were completed and reviewed by all licensed staff. Labeling of date open was reviewed with licensed staff. Audits of medication carts, diabetic cart and refrigerators will be completed weekly by Director of Nursing or designee. Continued monitoring will be the responsibility of the Director of Nursing, the Staff Development nurse and MDS nurse, or designee.	

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F 755	Continued From page 42 R26 with an open date of 4/18/18, was observed. Registered nurse (RN)-C stated Novolog insulin was good for 28 after it was opened. RN-C verified that R26's Novolog was expired. RN-C stated that R26 had received 14 doses of expired Novolog. R57's MAR for May 2018, identified R57 received humalog (a fast acting insulin used to reduce blood sugar levels) three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Humalog insulin for R57 with an open date of 4/19/18, was observed. Registered nurse (RN)-C stated Humalog insulin was good for 28 after it was opened. RN-C verified that R57's Humalog was expired. RN-C stated that R57 had received 8 doses of expired Humalog. R70's MAR for May 2018, identified R70 received Novolog three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Novolog insulin for R70 with an open date of 4/19/18, was observed. Registered nurse (RN)-C verified that R70's Novolog was expired. RN-C stated that R70 had received 14 doses of expired Novolog. R1's MAR for May 2018, identified R1 received Novolog three times a day. On 5/20/18, at 12:59 p.m., during observations of medication storage, a vial of Novolog insulin for R1 with an open date of 4/21/18, was observed. Licensed practical nurse (LPN)-C verified that R1's Novolog was expired. RN-C stated that R1 had received 5 doses of expired Novolog. LPN -C stated before drawing up a dose of insulin, staff should check the label for right medication, right resident and to check if the insulin was expired. If	F 755	The data will be presented to QAPI quarterly in July and October, then ongoing as needed	

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F 755	Continued From page 43 expired replace the insulin. During interview on 5/20/18, at 6:52 p.m. the director of nurses (DON) stated staff should check all medications for expiration dates especially insulin. The DON stated staff were not to give the residents expired medications. Food and Drug Administration Novolog drug insert dated 2/15, indicated "Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or light."	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 761		7/2/18

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F 761	Continued From page 44 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure un-authorized staff did not have access to 1 of 3 treatment carts used for storage of backup medications including house stock, prescriptions pills, injectable medications, inhalers and treatment cream/powder. Findings include: On 5/21/18, at 9:37 a.m. nursing assistant (NA)-B unlocked a medication/treatment cart parked in the hallway outside the day room across from the second floor nursing station. At the time of the observation licensed practical nurse (LPN)-A was seated at the desk looking through papers and was not observing NA-B. NA-B opened the fourth drawer and obtained a bottle of Nystatin (powder used to treat yeast infections) closed the drawer, locked the cart, returned the key to LPN-A then went into R3's room and shut the door. At 10:08 a.m. when asked about the Nystatin powder from the treatment cart, NA-B stated she had assisted R3 to wash under the breast and abdominal folds then she had applied the powder for R3 due to redness in the areas. When asked if she was a trained medication aide (TMA) NA-B stated "no am a nursing assistant." When asked if she was supposed to have access to the treatment cart keys NA-B stated she had told LPN-A she needed the powder and LPN-A had handed her the key to access the cart.	F 761	Licensed staff reviewed the Storage of Medication Policy. Direct Care Staff have been educated to the use of barrier cream and not to enter the medication carts. Pool Staff were updated by the Agency to the Policy before they enter the building. All Staff will be informed that nobody other than a nurse or TMA ever may have the keys to medication carts during All Staff meetings on June 26 and June 28. Random audits will take place on the floors once a week for four weeks, then monthly for 2 months. Continued monitoring will be the responsibility of the Director of Nursing, the Staff Development nurse, or designee. The data will be presented to QAPI in July and October then ongoing as needed.	

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F 761	Continued From page 45 At 10:25 a.m. when asked if NA-B was supposed to have access to treatment cart and keys LPN-A stated, because residents preferred certain staff to put the creams on he would give the NA's the cream to apply. When asked what the facility policy was for NA's accessing to the medication and treatment carts keys LPN-A stated "Am from the pool I don't know." At 10:29 a.m. TMA-A stated the NA's were not supposed to have access to the medication and treatment carts as back up medications were stored on the treatment cart for the entire floor. On 5/21/18, at 2:29 p.m. the director of nursing (DON) stated she had been made aware and nursing assistants were not supposed to have access to the keys. The DON stated she had talked to LPN-A. On 5/21/18, at 3:54 p.m. TMA-B stated the treatment cart was used as storage for medications which included house stock medications and prescription medications for multiple residents in the unit. She stated the NA's were not supposed to have access to the treatment cart. The Storage of Medications policy and procedure revised 11/2012, directed the staff to ensure keys to the carts were to be kept by the medication passer and/or nurse on the floor in their pocket and were to be given to the incoming staff at the end of the shift.	F 761		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse	F 814		7/2/18

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F 814	Continued From page 46 properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper containment of garbage in the outside dumpster to prevent attracting pests and rodents. This had the potential to affect all 83 residents residing at the facility. Findings include: On 5/20/18, at 12:49 p.m. during a tour of the facility with the dietary aide/cook, the garbage dumpster located in the back of the building was note to have approximately 20 bags of garbage on the ground. The trash dumpster was filled over the top and was open. Dietary aide/cook stated the staff were putting the garbage bags on the ground because the dumpster had been overflowing since Friday. In addition to the bags, the entire area around the dumpster was littered with food and trash which was spilling from puncture holes in the bags. The dietary aide/cook acknowledged both the dietary staff and all departments had used the dumpster during the last two days since staff did not know where to put the garbage. The dietary aide indicated the garbage was attracting rodents and animals to the area. and stated it was not good. On 5/21/18, at 8:54 a.m. the dietary manager stated housekeeping had called the garbage company Friday and they told the facility a car was blocking the area. She acknowledged all the garbage bags on the ground and and odor due to the open bags with food was spilling out. The dumpster was overflowing with garbage bags and was open. On the ground next to the cardboard container were at least another 20 bags of	F 814	Housekeeping notified the garbage company on 5/18/18 that the garbage was not picked up. They were told that the garbage company would pick up on 5/19/18. This was not done resulting in the conditions that the Health Department found on 5/10/18. A No Parking sign has been placed on the dumpster 6/13/18 to indicate there is no parking in the area. Garbage pickup will be monitored by the Maintenance Director or designee checking the garbage by 1 p.m. on pick up days and call the garbage company if it is not picked up. The garbage company states they will pick up same day if notified by 2 p.m. At the same time they will monitor for garbage and debris in the parking lot.	

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(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 814	Continued From page 47 garbage in a pile. On 5/21/18, at 4:25 p.m. during a follow up observation of the dumpster area, foam cups and other loose garbage were observed on the ground. During the observation the dietary manager stated she thought the trash may have been thrown by the residents residing at the facility next door. The dietary manager stated the facility did not have a policy per the administrator.	F 814		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		7/2/18

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 _____	05/23/2018

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 880	Continued From page 48 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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

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F 880	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control techniques while providing incontinence care for 1 of 1 residents (R36). Findings include: R36's quarterly minimum data set dated 3/20/18, indicated she was cognitively impaired and required extensive assist of two staff for transfers and toileting. R36's care plan dated 3/20/18, identified dependence on staff for assistance with all cares. The care plan directed staff to provide extensive assistance with hygiene which included pericare, dressing and hygiene related to daily tasks. On 5/22/18, at 10:33 a.m. nursing assistant (NA)-B and NA-C entered R36's room. Both NA's approached R36 and cued resident they were going to get her up for lunch. NA-B removed the covers and as R36 was swinging her feet to a sitting position, both NA's identified R36 had been incontinent of stool. NA-B and NA-C then applied gloves and a transfer belt around R36's waist and cued her to stand and transfer to the wheelchair. NA-B then folded a disposable waterproof pad with evidence of stool on it and set it top of bed spread by the foot of the bed. NA-B then removed gloves and left the room without washing hands. NA-A went down the hallway into a shared bathroom, came out with plastic bags and returned to R36's room. At 10:36 a.m. NA-C wheeled R36 into the shared bathroom and cued R36 to hold onto the grab bar as she stood. NA-A then removed the incontinent pad which had stool on it and tossed it in the garbage. NA-C	F 880	R36 was observed for infections or changes in overall condition. All residents on second floor have been reviewed for fevers, infections or changes in condition. Infection Preventionist and Director of nursing have reviewed the last three months of infections looking for patterns. All staff received education on infection control techniques, hand washing and glove usage. Included in education is education on regard facility infection prevention and control process. The Director of Nursing, Staff Development Nurse or designee will audit cares twice a week for four weeks, monthly for 2 months and as needed. Continued monitoring will be the responsibility of the Director of Nursing, the Staff Development Nurse, or designee. The data will be presented to QAPI in July and October, then ongoing as needed.	

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F 880	Continued From page 50	F 880		

pulled the portable toilet seat behind R36 and cued R36 to sit. NA-C then wheel R36 to the toilet and as R36 sat on the toilet and NA-C and NA-A removed R36's dress which was soiled. At 10:38 a.m. NA-A provided pericare to R36's front as she sat on the toilet. NA-A's right glove and the wipes used to cleaned R36 were soiled with stool. At 10:42 a.m., without washing hands or changing gloves, NA-A and NA-C wheeled R36 to the grab bar and cued her to stand. As R36 was standing NA-A was observed wipe stool off R36's bottom then then removed gloves and applied another pair without washing hands. At 10:43 a.m. NA-C also was observed to wipe stool off R36's bottom then removed gloves but did not wash hands. At this time NA-A applied a clean pad and then sat R36 in her wheelchair and applied a clean dress NA-B had brought in. At 10:44 a.m. NA-A and NA-C washed hands after adjusting R36's clothing.

On 5/22/18, at 12:23 p.m. NA-C stated she was supposed to wash hands after removing gloves following pericare.

At 12:27 p.m. NA-B stated she was supposed to wash her hands but she had left the room without washing hands to go grab the plastic bags.

At 12:31 p.m. NA-A stated she was supposed to wash her hands and stated she had not done so after completing pericare.

On 5/22/18, at 2:43 p.m. the director of nursing stated she would have expected the nursing assistants to wash their hands before, between and after cares and with glove changes.

The undated BYWOOD EAST Infection Control

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F 880	Continued From page 51 Standard Precautions Policy indicated hand hygiene continued to be the primary means of prevention of the transmission of infection. The policy directed hand hygiene was required at this situations: -When hands are visibly dirty and contaminated with proteinaceous material (compounds made up of amino acids or proteins), or visibly soiled with blood or body fluids, wash hands with soap and water. -If hands are not visibly soiled, or after removing the blood or body fluid with soap and water, decontaminate hands with an alcohol based hand rub which is the preferred method of hand hygiene. -After contact with blood, body fluids or excretions, mucous membranes non-intact skin or wound dressings (having used appropriate PPE's such as gloves). -After contact with a resident's intact skin such as taking a pulse or blood pressure, or lifting a resident. -If hands will be moving from a contaminated body-site to a clean body-site during cares.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 883		7/2/18

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F 883	Continued From page 52 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 883		

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F 883	Continued From page 53 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the current standards of vaccinations regarding influenza and pneumonia for 2 of 5 residents (R38, R71) whose vaccination histories were reviewed. Findings included: R38's Admission Record indicated an admission date of 12/11/17. R38's electronic health record (EHR) lacked evidence of an influenza immunization. A followup email from the director of nursing (DON) dated 5/24/18, at 12:27 p.m. indicated R38 went to the hospital from 8/23/17 - 12/11/17 and staff believed he must have received a 2017 influenza immunization, but neither EPIC (electronic privacy information center) or the Minnesota Immunization Report site confirmed he had received it in the hospital or in the facility. R71's Admission Record indicated an admission date of 5/14/02 and identified R71 was >65 years old. R71's EHR indicated a Pneumovax Dose 1 was given on 3/11/03 and on 3/2/12, but lacked any documentation indicating a pneumococcal vaccine was received. When asked during an interview on 5/23/18, at 1:21 p.m. if R71 had been offered, received or refused a PCV13 (Prevnar) registered nurse (RN-B) stated "not to my knowledge." Review of the facility Influenza Vaccine Policy and Procedure dated 3/10/17, indicated all residents	F 883	R71 was offered a pneumococcal shot with documentation per policy. R38 was not offered an influenza shot as it wouldn□t be relevant at this time. All resident records have been reviewed for status of pneumococcal immunization. The facility offered and documented per policy. Admission paperwork was amended to include both the influenza shot (Oct 1 to Mar 31) and pneumococcal immunization per standards to ensure to document if it was obtained elsewhere prior to admission. Resident are assisted to obtain shots by visiting out patient treatment, local pharmacy and at the facility when necessary. Staff Development/Infection Preventionist will monitor immunization compliance with each admission and with each flu season. Continued monitoring will be the responsibility of the Administrator, the Staff Development Nurse, or designee. The data will be presented to QAPI July and October, then ongoing as needed.	

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F 883	Continued From page 54 would be offered immunization against influenza and "a record of the vaccine given will be placed in the resident's medical record in the vaccination record." Review of the facility Pneumococcal Vaccine Policy and Procedure dated 3/14/17, indicated all residents would receive education regarding the benefits and potential side effects of the pneumococcal vaccine and be offered the vaccine according to CMS (Centers for Medicare and Medicaid) and CDC (Centers for Disease Control and Promotion). The policy further indicated those 65 years of age or older, or younger than 65 years with underlying conditions that are associated with increased susceptibility to infection or increased risk for serious disease and its complications should receive the vaccine.	F 883		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) 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 and interview, the facility failed to provide at least 80 square feet of space per resident in 11 multiple resident rooms, potentially affecting 27 residents occupying the rooms in the facility currently. 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:	F 912	Waiver is requested in attached letter	7/2/18

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F 912	Continued From page 55 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 During the survey the residents in these rooms did not offer complaints regarding room size.	F 912		

BYWOOD EAST
HEALTH CARE
a home for those unable to live alone

June 13, 2018

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P O Box 64900
St. Paul, MN 55164-0900

Dear Ms. Reuss,

Bywood East Health Care respectfully requests a waiver of Federal requirement F458 for the following rooms: 101,102, 107, 108, 109, 202, 301, 302, 307, 308, and 309.

We believe that some room sizes are in accordance with resident's special needs and will not and have not endangered the health or safety of the residents. Emergency personnel such as firemen and medics 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.

If you have any questions, please contact me at my office direct line 612-677-2741.

Thank you for your consideration of this waiver.

Sincerely,

Annette Thorson

Annette Thorson
Administrator

3427 Central Avenue NE | Minneapolis, Minnesota 55418
Phone: (612) 788.9757 | Fax: (612) 789.6564 | Web: www.bywoodeast.com

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 _____	**05/22/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC 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. UPON RECEIPT OF AN ACCEPTABLE POC, 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 22, 2018. At the time of this survey, Bywood East was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/18/2018

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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K 000	Continued From page 1 IS NOT REQUIRED.	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Bywood East is a 3-story building with a partial basement that was built in 1968 and was determined to be built of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system and 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 82 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 82 residents. Findings include: On a facility tour between the hours of 1100 and 1500 on May 22, 2018, it was revealed that the facility could not provide evidence of having completed quarterly sprinkler drain tests.	K 353	The sprinkler drain test was conducted by the Maintenance Director under supervision of the sprinkler system contractor on 6/15/18. This task will be placed on the Maintenance calendar to conduct quarterly in March, June, September, December of each year. The administrator will check that the drain test has been conducted and documented appropriately.	6/29/18

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	24E185	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/22/2018**

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K 353	Continued From page 3 This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 353		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with	K 923		5/24/18

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 _____	**05/22/2018**

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
K 923	Continued From page 4 integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, that facility did not properly store oxygen cylinders in accordance with NFPA 99. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5. This deficient practice could affect all residents in the smoke compartment. Findings include: On a facility tour between the hours of 1100 and 1500 on May 22, 2018, it was revealed that the oxygen storage room had a hole in the ceiling drywall which would allow for the passage of smoke. These deficient practices was verified by the Director of Maintenance at the time of discovery.	K 923	The hole in the ceiling drywall was repaired by a contractor on 5/23/18. The Maintenance Director or designee will check monthly when the fire extinguishers are checked.	

Electronically delivered
June 8, 2018

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number SE185027

Dear Ms. Thorson:

The above facility was surveyed on May 20, 2018 through May 23, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 Nursing 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the 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.

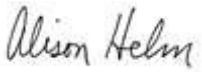
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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. 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 immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793 or susanne.reuss@state.mn.us.

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.

Please feel free to call me with any questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

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 _____	05/23/2018

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 *****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	3 000		

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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 5/20/18 through 5/23/18, 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.	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 be maintained by the boarding care home. This MN Requirement is not met as evidenced by:	3 601		7/2/18

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3 601	Continued From page 3 Based on interview and document review, the agency failed to ensure 4 of 5 employees (E-1, E-2, E-4, E-5) had proper evaluation and documentation for tuberculosis (TB) testing and screening. In addition, the facility failed to accurately assess the TB risk for the facility. This had the potential to affect all 83 clients in the facility. Findings include: Employees E-1's personnel file review revealed a hire date of 11/1/17. E-1 had TB symptom screening completed on 11/1/17. A step one Tuberculin Skin Test (TST) was administered on 10/27/17, read on 10/30/17, with 0 millimeters (mm) but no interpretation of the result. There was no second step TST administered. E-2's personnel file review revealed a hire date of 1/18/18. E-2 had no TB symptom screening completed on 1/18/18. A chest x-ray was completed on 6/4/17, with pictures of the chest x-rays in the file, however there was no physician's medical evaluation to rule out infectious TB. E-4's personnel file review revealed a start date in the facility of 1/31/18. E-4 had no TB symptom screening completed on 1/31/18. A chest x-ray was completed on 9/13/17, with negative chest TB interpretation. E-5's personnel file review revealed a start date in the facility of 2/7/18. E-5 had no TB symptom screening completed on 2/7/18. A medical report dated 3/15/18, indicated E-5's chest x-ray was normal and did not show any sign of active TB.	3 601	A system has been developed to monitor the tuberculosis infection control guidelines and ensure staff remain in compliance.	

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3 601	Continued From page 4 During interview on 5/23/18, at 11:58 a.m. the director of nursing (DON) verified E2's symptom screen was not in her file and for E-4 and E-5, "I believe we won't find any, it's the pools' responsibility, we did not do any symptom screening." TB risk assessment: The facility's Tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health was completed on 3/1/17. The "1. Incidence of TB" section noted the rate of TB incidents in the community was 4.7, in the state was 2.7, and the national rate was 3.0, indicated the facility's health care setting was medium risk and indicated the TB risk assessment would be updated annually. There was no indication the most current data was reviewed and included in the TB risk assessment. On 5/23/18, at 2:02 p.m. the DON provided an incomplete Facility TB Risk Assessment worksheet with no completion date. The DON acknowledged a former employee had completed it but was not sure if it was submitted. A follow up email dated 5/24/18, at 12:27 p.m. included a submission of the Facility TB Risk Assessment dated 5/24/18. On 5/23/18, at 3:38 p.m. the DON stated they did not have a TB or influenza policy, "I need to find them." TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 601		
31145	MN Rule 4655.7830 Subp. 4 Medication Containers;Out of date medications	31145		7/2/18

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31145	Continued From page 5 Subp. 4. Out of date medications. Medications having a specific expiration date shall not be used after the date of expiration. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify when insulin was opened and/or identify when the insulin would expire, resulting in administration of expired insulin, for 4 of 14 residents (R26, R57, R70, R1) who were administered insulin. Findings include: R26's Medication Administration Record (MAR) for May 2018, identified R26 received Novolog (a fast acting insulin used to reduce blood sugar levels) three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Novolog insulin for R26 with an open date of 4/18/18, was observed. Registered nurse (RN)-C stated Novolog insulin was good for 28 after it was opened. RN-C verified that R26's Novolog was expired. RN-C stated that R26 had received 14 doses of expired Novolog. R57's MAR for May 2018, identified R57 received humalog (a fast acting insulin used to reduce blood sugar levels) three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Humalog insulin for R57 with an open date of 4/19/18, was observed. Registered nurse (RN)-C stated Humalog insulin was good for 28 after it was opened. RN-C verified that R57's Humalog was expired. RN-C stated that R57 had received 8 doses of expired	31145	Licensed nursing staff were in-serviced as to checking and documentation of opened vials of drugs and biological. DON or designee to monitor	

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31145	Continued From page 6 Humalog. R70's MAR for May 2018, identified R70 received Novolog three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Novolog insulin for R70 with an open date of 4/19/18, was observed. Registered nurse (RN)-C verified that R70's Novolog was expired. RN-C stated that R70 had received 14 doses of expired Novolog. R1's MAR for May 2018, identified R1 received Novolog three times a day. On 5/20/18, at 12:59 p.m., during observations of medication storage, a vial of Novolog insulin for R1 with an open date of 4/21/18, was observed. Licensed practical nurse (LPN)-C verified that R1's Novolog was expired. RN-C stated that R1 had received 5 doses of expired Novolog. LPN -C stated before drawing up a dose of insulin, staff should check the label for right medication, right resident and to check if the insulin was expired. If expired replace the insulin. During interview on 5/20/18, at 6:52 p.m. the director of nurses (DON) stated staff should check all medications for expiration dates especially insulin. The DON stated staff were not to give the residents expired medications. Food and Drug Administration Novolog drug insert dated 2/15, indicated "Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or light." TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31145		

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31460	Continued From page 7	31460		
31460	MN Rule 4655.9000 Subp. 2 Housekeeping; Cleaning Program Subp. 2. Development of cleaning program. A program shall be established for routine housekeeping. Besides the daily duties, the program shall include policies and procedures for any special cleaning necessary. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide an environment in a sanitary manner for 1 of 2 residents (R24). In addition failed to keep furniture in good repair to maintain cleanable surfaces. Findings include: R24's quarterly Minimum Data Set (MDS) dated 3/6/18, indicated R24 had moderately impaired cognition and required limited to extensive physical assistance of one staff with activities of daily living. On 5/20/18, at 6:03 p.m. when asked if the room was clean, R24 reached out to the privacy curtain in front of him by the television and multiple visible red brown stains were observed. R24 stated he did not even know what all those stains were. On 5/21/18, at 9:00 a.m. to 11:00 a.m. the privacy curtain was observed pulled all the way around R24's bed and the stains remained visible when entering R24's space. On 5/22/18, from 9:55 a.m. to 10:03 a.m. the	31460	All items listed have been corrected. Housekeeping and Maintenance staff to receive re-in-service on June 20,2018. Director of Maintenance and Administrator will monitor for compliance.	7/2/18

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31460	Continued From page 8	31460		

environmental tour was completed with the facility administrator and the director of maintenance and environmental services. During the tour the administrator verified the privacy curtain was soiled. When asked who was responsible for making sure the curtains were maintained clean and in a sanitary manner she stated housekeeping was supposed to do it when doing the room deep cleaning and was supposed to let maintenance know to remove them to get washed.

On 5/23/18, at 9:31 a.m. a metal frame chair with a pink seat was observed in the second for lounge. The chair had three holes in it exposing the fabric under the covering. A second wood framed chair had seven holes in the seat cover.

At 9:33 a.m. housekeeper-A was shown the chairs and was asked how the chairs would be cleaned. Housekeeper-A stated the chairs were wiped off with a sanitizing solution. When asked about being able to sanitize them with the holes in the chair, housekeeper-A stated the chairs could not be sanitized. When asked what the procedure was when furniture or equipment was broken. Housekeeper-A stated she would report it to the maintenance director.

During interview at 10:13 a.m the maintenance director (MD) stated the chairs needed to be replaced. When asked what would be done in the meantime, MD stated "I don't suppose I can cover them with duct tape." When asked about a log or the system for reporting furniture the MD stated he was not aware if there was a log or system, but would get the information. At 11:34 AM MD reported the chairs were removed from the second floor lounge and explained when there was furniture or equipment needing repair

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31460	Continued From page 9 or removal the staff filled out a maintenance request. Those requests were given to the maintenance staff. MD added there was no log for tracking maintenance requests, but stated when the maintenance staff completed the task the request was signed off on and placed in a completion file. On 2/23/18, at 2:00 p.m. during interview, the Administrator stated the facility did not have a policy or procedure related to reporting when furniture or equipment needed repair or replacement, but the staff were told at orientation what the process was and how to fill out the maintenance request slip. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31460		
31805	MN Rule 144.651 Subd. 5 Patients & Residents of HCF Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R36) was provided privacy during cares. Findings include: R36's quarterly minimum data set dated 3/20/18,	31805	Nursing staff were in-serviced during the week of May 20. All Staff in-serviced June 26 and June 28. The interdisciplinary team will monitor through audits.	7/2/18

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	00176	A. BUILDING: _____ B. WING _____	05/23/2018

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) COMPLETE DATE
31805	Continued From page 10	31805		

indicated she was cognitively impaired and required extensive assist of two staff for transfers and toileting. R36's care plan dated 3/20/18, identified dependence on staff for assistance with all cares and directed staff to provide extensive assistance with hygiene which included pericare, dressing and hygiene related to daily tasks.

During observation on 5/22/18, at 10:33 a.m. nursing assistants (NA)-B and NA-C entered R36's room. Both NA's approached R36 and cued her they were going to get her up for lunch. NA-B took the covers off and as R36 was swinging her feet to a sitting position, both NA's identified R36 had been incontinent of stool. NA-B and NA-C applied gloves and a transfer belt around R36's waist then assisted R36 to stand and transfer to the wheelchair. At 10:36 a.m. NA-C wheeled R36 into the shared bathroom and cued R36 to hold onto the grab bar as she stood. NA-A then removed the incontinent pad and tossed it in the garbage. NA-C then pulled the portable toilet seat behind R36 and cued R36 to sit. NA-C then wheeled R36 to the toilet and as R36 sat on the toilet and NA-C and NA-A removed R36's dress which was soiled. From 10:38 a.m. to 10:41 a.m. R36 sat on the toilet chair naked as she spoke in a language NA-A and NA-C did not understand. Without attempting to cover R36, NA-A provided care while she sat on the toilet naked. At 10:42 a.m. NA-A and NA-C wheeled R36 to the grab bar and cued her to stand. R36 was still exposed and staff did not attempt to cover her. NA-A applied a clean pad and then sat R36 in her wheelchair and put a clean dress on her.

On 5/22/18, at 12:23 p.m. NA-C acknowledged they had left R36 naked during the cares. NA-C stated "we should have covered her."

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31805	Continued From page 11 -At 12:27 p.m. NA-B stated they were supposed to provide R36 privacy by covering her. -At 12:31 p.m. NA-A stated she was supposed to provide residents with privacy and acknowledged they were supposed to have used a towel or gown to cover R36 as they were waiting other NA-B to bring another dress. On 5/22/18, at 2:43 p.m. the director of nursing stated the NA's should have applied a gown on R36 to promote dignity. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31805		
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	31980		7/2/18

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31980	Continued From page 12 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. (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 report allegations of abuse to the state agency (SA) for 1 of 3 residents (R74) reviewed for abuse.	31980	Incidents are reviewed daily M-F by the interdisciplinary team to determine if an allegation that should have been reported was missed. Director of Social Services will monitor	

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31980	Continued From page 13 Findings include: R74's quarterly Minimum Data Set (MDS) dated 5/10/18, indicated he was cognitively intact, independent with daily decision making and displayed only verbal behavioral symptoms toward others. R74's care plan dated 11/17/17,revealed resident had areas of vulnerability due to cognitive deficits and inaccessibility to family members. Identified goals included: resident will have minimized risk of abuse. R74's care plan instructed staff to remove resident from the aggressor and relocate to a safe location, observe and provide a safe environment and report vulnerable adults to the state agency according to policy. A review of Resident Incident Reports identified the following: 12/11/17, indicated R74 reported to staff roommate R5 was aggressive toward him. R74 stated he did not want to wake up with a knife to his throat. Staff instructed R5 to stay away from R74. Interdisciplinary team (IDT) comments dated 12/13/17, on Resident Incident Report indicated offered different room, put on list well checks alcohol behavior. Resident Incident Report section on potential vulnerable adult issue was blank. 2/22/18, indicated R74 was struck by R5 with a closed fist when R74 told R5 not to touch a staff member. IDT comments dated 2/23/18, on Resident Incident Report indicated offered different room, resident refused assist with calling police if needed. Resident Incident Report section on potential vulnerable adult issue was blank.	31980		

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31980	Continued From page 14 4/15/18, indicated R74 reported to staff, his side really hurt and said, "I don't need to put up with this pain." R74 showed staff two purple bruises under his left breast approximately two centimeters in diameter. When asked how he got the bruises R74 said, "My Room mate." IDT comments dated 4/23/18, on Resident Incident Report indicated monitor bruises until healed. Resident Incident Report section on potential vulnerable adult issue was blank. 4/24/18, at 1:30 p.m. indicated R74 made repeated verbal threats toward staff. Police were called and spoke with R74. a second Resident Incident Report at 8:20 p.m. indicated staff witnessed R48 run toward R74 yelling at him to leave. R48 then shoved R74 against the wall causing him to slip and nearly fall. Back of Resident Incident Report blank. Suspected Substance Abuse form attached to the Resident Incident Reports and indicated R74 admitted to having a few drinks. All forms were attached to each other. IDT comments dated 4/25/18, on Resident Incident Report dated 4/24/18, at 1:30 p.m. indicated, "30 day notice, 911 hospital Left AMA[against medical advice], came to facility & [and] left gain 2 [secondary to] police escort." signed by the DON Resident Incident Report section on potential vulnerable adult issue was blank. During interview on 5/23/18, at 2:06 p.m. the director of nursing (DON) stated the incident on 2/22/18, was not reported to the SA but was reported to the police. She stated she did not believe R5 wanted to hurt R74 and was being protective of the staff. Regarding an investigations, the DON stated she only had the incident report and the nurses notes. In regard to the incident on 4/15/18, the DON indicated R74's	31980		

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31980	Continued From page 15 bruising was related to a medical diagnosis that affected his clotting time and stated, he had bruises. She stated she did not have an investigation in front of her at the time, but was sure one was done. In regards to the incident on 4/24/18 of R74 being shoved into the wall by R48 the DON stated she had never seen that R74 had been shoved on that until reviewing incident reports with surveyor. DON stated the incident of R48 shoving R74 into the wall should have been reported. The DON stated there was no additional investigation but the information that was on the Resident Incident Reports. the DON stated if the incidents had been reported, a more detailed investigation would have been completed. A facility policy titled Vulnerable Adult Abuse Prevention Policy dated 2/1/17, indicated the facility does not tolerate any forms of abuse. The policy defined physical abuse as, but not limited to hitting, kicking, slapping and punching. Initial notification to the SA will be completed immediately following evaluation of the incident involving suspected abuse or mistreatment. 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	32000		7/2/18

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32000	Continued From page 16 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. (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.	32000		

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32000	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thotoughly investigate allegations of abuse for 1 of 3 residents (R74) reviewed for abuse. Findings include: A facility policy titled Vulnerable Adult Abuse Prevention Policy dated 2/1/17, indicated the facility does not tolerate any forms of abuse. Upon receiving a report of an incident, the resident will be assessed and an investigation inititate. The investigation shall include interviews of the ivolved resident, family members, interdisciplinary team and any others who may have information about the event. R74's quarterly Minimum Data Set (MDS) dated 5/10/18, indicated he was cognitively intact, independent with daily decision making and displayed only verbal behavioral symptoms toward others. R74's care plan dated 11/17/17,revealed resident had areas of vulnerability due to cognitive deficits and inaccessibility to family members. Identified goals included: resident will have minimized risk of abuse. R74's care plan instructed staff to remove resident from the aggressor and relocate to a safe location, observe and provide a safe environment and report vulnerable adults to the state agency according to policy. A review of Resident Incident Reports identified the following: 12/11/17, indicated R74 reported to staff	32000	Incidents are reviewed daily M-F by the interdisciplinary team to determine if an allegation that should have been investigated was missed. Director of Social Services will monitor	

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32000	Continued From page 18	32000		

roommate R5 was aggressive toward him. R74 stated he did not want to wake up with a knife to his throat. Staff instructed R5 to stay away from R74. Interdisciplinary team (IDT) comments dated 12/13/17, on Resident Incident Report indicated offered different room, put on list well checks alcohol behavior. Resident Incident Report section on potential vulnerable adult issue was blank. The record lacked evidence of an investigation following the incident.

2/22/18, indicated R74 was struck by R5 with a closed fist when R74 told R5 not to touch a staff member. IDT comments dated 2/23/18, on Resident Incident Report indicated offered different room, resident refused assist with calling police if needed. Resident Incident Report section on potential vulnerable adult issue was blank.The record lacked evidence of an investigation following the incident.

4/15/18, indicated R74 reported to staff, his side really hurt and said, "I don't need to put up with this pain." R74 showed staff two purple bruises under his left breast approximately two centimeters in diameter. When asked how he got the bruises R74 said, "My Room mate." IDT comments dated 4/23/18, on Resident Incident Report indicated monitor bruises until healed. Resident Incident Report section on potential vulnerable adult issue was blank. The record lacked evidence of an investigation following the incident.

4/24/18, at 1:30 p.m. indicated R74 made verbal threats toward staff. Police were called and spoke with R74. a second Resident Incident Report at 8:20 p.m. indicated staff witnessed R48 run toward R74 yelling at him to leave. R48 then shoved R74 against the wall causing him to slip

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32000	Continued From page 19 and nearly fall. Back of Resident Incident Report blank. Suspected Substance Abuse form attached to the Resident Incident Reports and indicated R74 admitted to having a few drinks. All forms were attached to each other. IDT comments dated 4/25/18, on Resident Incident Report dated 4/24/18, at 1:30 p.m. indicated, "30 day notice, 911 hospital Left AMA[against medical advice], came to facility & [and] left gain 2 [secondary to] police escort." signed by the DON Resident Incident Report section on potential vulnerable adult issue was blank. The record lacked evidence of an investigation following the incident. During interview on 5/23/18, at 2:06 p.m. the director of nursing (DON) stated the incident on 2/22/18, was not reported to the SA but was reported to the police. The DON stated, looking back, she did not know why a report was not made to the SA. She stated she did not believe R5 wanted to hurt R74 and was being protective of the staff. In regard to the incident on 4/15/18, the DON stated it was not reported to the SA because the bruises were not injuries of unknown origin. She stated the interdisciplinary team met and discussed the incident and determined it was not reportable. She indicated R74's bruising was related to a medical diagnosis that affected his clotting time and stated, he had bruises. In regards to the incident on 4/24/18 of R74 being shoved into the wall by R48 the DON stated she had never seen that R74 had been shoved on that until reviewing incident reports with surveyor. DON stated the incident of R48 shoving R74 into the wall should have been reported. The DON stated there was no additional investigation but the information that was on the Resident Incident Reports. the DON stated if the incidents had been reported, a more detailed investigation would	32000		

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32000	Continued From page 20 have been completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	32000		

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3 000	INITIAL COMMENTS *****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	3 000		

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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 5/20/18 through 5/23/18, 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.	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 be maintained by the boarding care home. This MN Requirement is not met as evidenced by:	3 601		7/2/18

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	00176	A. BUILDING: _____ B. WING _____	05/23/2018

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3 601	Continued From page 3 Based on interview and document review, the agency failed to ensure 4 of 5 employees (E-1, E-2, E-4, E-5) had proper evaluation and documentation for tuberculosis (TB) testing and screening. In addition, the facility failed to accurately assess the TB risk for the facility. This had the potential to affect all 83 clients in the facility. Findings include: Employees E-1's personnel file review revealed a hire date of 11/1/17. E-1 had TB symptom screening completed on 11/1/17. A step one Tuberculin Skin Test (TST) was administered on 10/27/17, read on 10/30/17, with 0 millimeters (mm) but no interpretation of the result. There was no second step TST administered. E-2's personnel file review revealed a hire date of 1/18/18. E-2 had no TB symptom screening completed on 1/18/18. A chest x-ray was completed on 6/4/17, with pictures of the chest x-rays in the file, however there was no physician's medical evaluation to rule out infectious TB. E-4's personnel file review revealed a start date in the facility of 1/31/18. E-4 had no TB symptom screening completed on 1/31/18. A chest x-ray was completed on 9/13/17, with negative chest TB interpretation. E-5's personnel file review revealed a start date in the facility of 2/7/18. E-5 had no TB symptom screening completed on 2/7/18. A medical report dated 3/15/18, indicated E-5's chest x-ray was normal and did not show any sign of active TB.	3 601	A system has been developed to monitor the tuberculosis infection control guidelines and ensure staff remain in compliance.	

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3 601	Continued From page 4 During interview on 5/23/18, at 11:58 a.m. the director of nursing (DON) verified E2's symptom screen was not in her file and for E-4 and E-5, "I believe we won't find any, it's the pools' responsibility, we did not do any symptom screening." TB risk assessment: The facility's Tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health was completed on 3/1/17. The "1. Incidence of TB" section noted the rate of TB incidents in the community was 4.7, in the state was 2.7, and the national rate was 3.0, indicated the facility's health care setting was medium risk and indicated the TB risk assessment would be updated annually. There was no indication the most current data was reviewed and included in the TB risk assessment. On 5/23/18, at 2:02 p.m. the DON provided an incomplete Facility TB Risk Assessment worksheet with no completion date. The DON acknowledged a former employee had completed it but was not sure if it was submitted. A follow up email dated 5/24/18, at 12:27 p.m. included a submission of the Facility TB Risk Assessment dated 5/24/18. On 5/23/18, at 3:38 p.m. the DON stated they did not have a TB or influenza policy, "I need to find them." TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 601		
31145	MN Rule 4655.7830 Subp. 4 Medication Containers;Out of date medications	31145		7/2/18

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31145	Continued From page 5 Subp. 4. Out of date medications. Medications having a specific expiration date shall not be used after the date of expiration. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify when insulin was opened and/or identify when the insulin would expire, resulting in administration of expired insulin, for 4 of 14 residents (R26, R57, R70, R1) who were administered insulin. Findings include: R26's Medication Administration Record (MAR) for May 2018, identified R26 received Novolog (a fast acting insulin used to reduce blood sugar levels) three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Novolog insulin for R26 with an open date of 4/18/18, was observed. Registered nurse (RN)-C stated Novolog insulin was good for 28 after it was opened. RN-C verified that R26's Novolog was expired. RN-C stated that R26 had received 14 doses of expired Novolog. R57's MAR for May 2018, identified R57 received humalog (a fast acting insulin used to reduce blood sugar levels) three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Humalog insulin for R57 with an open date of 4/19/18, was observed. Registered nurse (RN)-C stated Humalog insulin was good for 28 after it was opened. RN-C verified that R57's Humalog was expired. RN-C stated that R57 had received 8 doses of expired	31145	Licensed nursing staff were in-serviced as to checking and documentation of opened vials of drugs and biological. DON or designee to monitor	

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31145	Continued From page 6 Humalog. R70's MAR for May 2018, identified R70 received Novolog three times a day. On 5/20/18, at 11:45 a.m., during observations of medication storage, a vial of Novolog insulin for R70 with an open date of 4/19/18, was observed. Registered nurse (RN)-C verified that R70's Novolog was expired. RN-C stated that R70 had received 14 doses of expired Novolog. R1's MAR for May 2018, identified R1 received Novolog three times a day. On 5/20/18, at 12:59 p.m., during observations of medication storage, a vial of Novolog insulin for R1 with an open date of 4/21/18, was observed. Licensed practical nurse (LPN)-C verified that R1's Novolog was expired. RN-C stated that R1 had received 5 doses of expired Novolog. LPN -C stated before drawing up a dose of insulin, staff should check the label for right medication, right resident and to check if the insulin was expired. If expired replace the insulin. During interview on 5/20/18, at 6:52 p.m. the director of nurses (DON) stated staff should check all medications for expiration dates especially insulin. The DON stated staff were not to give the residents expired medications. Food and Drug Administration Novolog drug insert dated 2/15, indicated "Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or light." TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31145		

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31460	Continued From page 7	31460		
31460	MN Rule 4655.9000 Subp. 2 Housekeeping; Cleaning Program Subp. 2. Development of cleaning program. A program shall be established for routine housekeeping. Besides the daily duties, the program shall include policies and procedures for any special cleaning necessary. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide an environment in a sanitary manner for 1 of 2 residents (R24). In addition failed to keep furniture in good repair to maintain cleanable surfaces. Findings include: R24's quarterly Minimum Data Set (MDS) dated 3/6/18, indicated R24 had moderately impaired cognition and required limited to extensive physical assistance of one staff with activities of daily living. On 5/20/18, at 6:03 p.m. when asked if the room was clean, R24 reached out to the privacy curtain in front of him by the television and multiple visible red brown stains were observed. R24 stated he did not even know what all those stains were. On 5/21/18, at 9:00 a.m. to 11:00 a.m. the privacy curtain was observed pulled all the way around R24's bed and the stains remained visible when entering R24's space. On 5/22/18, from 9:55 a.m. to 10:03 a.m. the	31460	All items listed have been corrected. Housekeeping and Maintenance staff to receive re-in-service on June 20,2018. Director of Maintenance and Administrator will monitor for compliance.	7/2/18

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31460	Continued From page 8	31460		

environmental tour was completed with the facility administrator and the director of maintenance and environmental services. During the tour the administrator verified the privacy curtain was soiled. When asked who was responsible for making sure the curtains were maintained clean and in a sanitary manner she stated housekeeping was supposed to do it when doing the room deep cleaning and was supposed to let maintenance know to remove them to get washed.

On 5/23/18, at 9:31 a.m. a metal frame chair with a pink seat was observed in the second for lounge. The chair had three holes in it exposing the fabric under the covering. A second wood framed chair had seven holes in the seat cover.

At 9:33 a.m. housekeeper-A was shown the chairs and was asked how the chairs would be cleaned. Housekeeper-A stated the chairs were wiped off with a sanitizing solution. When asked about being able to sanitize them with the holes in the chair, housekeeper-A stated the chairs could not be sanitized. When asked what the procedure was when furniture or equipment was broken. Housekeeper-A stated she would report it to the maintenance director.

During interview at 10:13 a.m the maintenance director (MD) stated the chairs needed to be replaced. When asked what would be done in the meantime, MD stated "I don't suppose I can cover them with duct tape." When asked about a log or the system for reporting furniture the MD stated he was not aware if there was a log or system, but would get the information. At 11:34 AM MD reported the chairs were removed from the second floor lounge and explained when there was furniture or equipment needing repair

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31460	Continued From page 9 or removal the staff filled out a maintenance request. Those requests were given to the maintenance staff. MD added there was no log for tracking maintenance requests, but stated when the maintenance staff completed the task the request was signed off on and placed in a completion file. On 2/23/18, at 2:00 p.m. during interview, the Administrator stated the facility did not have a policy or procedure related to reporting when furniture or equipment needed repair or replacement, but the staff were told at orientation what the process was and how to fill out the maintenance request slip. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31460		
31805	MN Rule 144.651 Subd. 5 Patients & Residents of HCF Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R36) was provided privacy during cares. Findings include: R36's quarterly minimum data set dated 3/20/18,	31805	Nursing staff were in-serviced during the week of May 20. All Staff in-serviced June 26 and June 28. The interdisciplinary team will monitor through audits.	7/2/18

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31805	Continued From page 10	31805		

indicated she was cognitively impaired and required extensive assist of two staff for transfers and toileting. R36's care plan dated 3/20/18, identified dependence on staff for assistance with all cares and directed staff to provide extensive assistance with hygiene which included pericare, dressing and hygiene related to daily tasks.

During observation on 5/22/18, at 10:33 a.m. nursing assistants (NA)-B and NA-C entered R36's room. Both NA's approached R36 and cued her they were going to get her up for lunch. NA-B took the covers off and as R36 was swinging her feet to a sitting position, both NA's identified R36 had been incontinent of stool. NA-B and NA-C applied gloves and a transfer belt around R36's waist then assisted R36 to stand and transfer to the wheelchair. At 10:36 a.m. NA-C wheeled R36 into the shared bathroom and cued R36 to hold onto the grab bar as she stood. NA-A then removed the incontinent pad and tossed it in the garbage. NA-C then pulled the portable toilet seat behind R36 and cued R36 to sit. NA-C then wheeled R36 to the toilet and as R36 sat on the toilet and NA-C and NA-A removed R36's dress which was soiled. From 10:38 a.m. to 10:41 a.m. R36 sat on the toilet chair naked as she spoke in a language NA-A and NA-C did not understand. Without attempting to cover R36, NA-A provided care while she sat on the toilet naked. At 10:42 a.m. NA-A and NA-C wheeled R36 to the grab bar and cued her to stand. R36 was still exposed and staff did not attempt to cover her. NA-A applied a clean pad and then sat R36 in her wheelchair and put a clean dress on her.

On 5/22/18, at 12:23 p.m. NA-C acknowledged they had left R36 naked during the cares. NA-C stated "we should have covered her."

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31805	Continued From page 11 -At 12:27 p.m. NA-B stated they were supposed to provide R36 privacy by covering her. -At 12:31 p.m. NA-A stated she was supposed to provide residents with privacy and acknowledged they were supposed to have used a towel or gown to cover R36 as they were waiting other NA-B to bring another dress. On 5/22/18, at 2:43 p.m. the director of nursing stated the NA's should have applied a gown on R36 to promote dignity. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31805		
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	31980		7/2/18

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31980	Continued From page 12 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. (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 report allegations of abuse to the state agency (SA) for 1 of 3 residents (R74) reviewed for abuse.	31980	Incidents are reviewed daily M-F by the interdisciplinary team to determine if an allegation that should have been reported was missed. Director of Social Services will monitor	

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31980	Continued From page 13 Findings include: R74's quarterly Minimum Data Set (MDS) dated 5/10/18, indicated he was cognitively intact, independent with daily decision making and displayed only verbal behavioral symptoms toward others. R74's care plan dated 11/17/17,revealed resident had areas of vulnerability due to cognitive deficits and inaccessibility to family members. Identified goals included: resident will have minimized risk of abuse. R74's care plan instructed staff to remove resident from the aggressor and relocate to a safe location, observe and provide a safe environment and report vulnerable adults to the state agency according to policy. A review of Resident Incident Reports identified the following: 12/11/17, indicated R74 reported to staff roommate R5 was aggressive toward him. R74 stated he did not want to wake up with a knife to his throat. Staff instructed R5 to stay away from R74. Interdisciplinary team (IDT) comments dated 12/13/17, on Resident Incident Report indicated offered different room, put on list well checks alcohol behavior. Resident Incident Report section on potential vulnerable adult issue was blank. 2/22/18, indicated R74 was struck by R5 with a closed fist when R74 told R5 not to touch a staff member. IDT comments dated 2/23/18, on Resident Incident Report indicated offered different room, resident refused assist with calling police if needed. Resident Incident Report section on potential vulnerable adult issue was blank.	31980		

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31980	Continued From page 14 4/15/18, indicated R74 reported to staff, his side really hurt and said, "I don't need to put up with this pain." R74 showed staff two purple bruises under his left breast approximately two centimeters in diameter. When asked how he got the bruises R74 said, "My Room mate." IDT comments dated 4/23/18, on Resident Incident Report indicated monitor bruises until healed. Resident Incident Report section on potential vulnerable adult issue was blank. 4/24/18, at 1:30 p.m. indicated R74 made repeated verbal threats toward staff. Police were called and spoke with R74. a second Resident Incident Report at 8:20 p.m. indicated staff witnessed R48 run toward R74 yelling at him to leave. R48 then shoved R74 against the wall causing him to slip and nearly fall. Back of Resident Incident Report blank. Suspected Substance Abuse form attached to the Resident Incident Reports and indicated R74 admitted to having a few drinks. All forms were attached to each other. IDT comments dated 4/25/18, on Resident Incident Report dated 4/24/18, at 1:30 p.m. indicated, "30 day notice, 911 hospital Left AMA[against medical advice], came to facility & [and] left gain 2 [secondary to] police escort." signed by the DON Resident Incident Report section on potential vulnerable adult issue was blank. During interview on 5/23/18, at 2:06 p.m. the director of nursing (DON) stated the incident on 2/22/18, was not reported to the SA but was reported to the police. She stated she did not believe R5 wanted to hurt R74 and was being protective of the staff. Regarding an investigations, the DON stated she only had the incident report and the nurses notes. In regard to the incident on 4/15/18, the DON indicated R74's	31980		

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(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
31980	Continued From page 15 bruising was related to a medical diagnosis that affected his clotting time and stated, he had bruises. She stated she did not have an investigation in front of her at the time, but was sure one was done. In regards to the incident on 4/24/18 of R74 being shoved into the wall by R48 the DON stated she had never seen that R74 had been shoved on that until reviewing incident reports with surveyor. DON stated the incident of R48 shoving R74 into the wall should have been reported. The DON stated there was no additional investigation but the information that was on the Resident Incident Reports. the DON stated if the incidents had been reported, a more detailed investigation would have been completed. A facility policy titled Vulnerable Adult Abuse Prevention Policy dated 2/1/17, indicated the facility does not tolerate any forms of abuse. The policy defined physical abuse as, but not limited to hitting, kicking, slapping and punching. Initial notification to the SA will be completed immediately following evaluation of the incident involving suspected abuse or mistreatment. 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	32000		7/2/18

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	00176	A. BUILDING: _____ B. WING _____	05/23/2018

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32000	Continued From page 16 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. (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.	32000		

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32000	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thotoughly investigate allegations of abuse for 1 of 3 residents (R74) reviewed for abuse. Findings include: A facility policy titled Vulnerable Adult Abuse Prevention Policy dated 2/1/17, indicated the facility does not tolerate any forms of abuse. Upon receiving a report of an incident, the resident will be assessed and an investigation inititate. The investigation shall include interviews of the ivolved resident, family members, interdisciplinary team and any others who may have information about the event. R74's quarterly Minimum Data Set (MDS) dated 5/10/18, indicated he was cognitively intact, independent with daily decision making and displayed only verbal behavioral symptoms toward others. R74's care plan dated 11/17/17,revealed resident had areas of vulnerability due to cognitive deficits and inaccessibility to family members. Identified goals included: resident will have minimized risk of abuse. R74's care plan instructed staff to remove resident from the aggressor and relocate to a safe location, observe and provide a safe environment and report vulnerable adults to the state agency according to policy. A review of Resident Incident Reports identified the following: 12/11/17, indicated R74 reported to staff	32000	Incidents are reviewed daily M-F by the interdisciplinary team to determine if an allegation that should have been investigated was missed. Director of Social Services will monitor	

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32000	Continued From page 18	32000		

roommate R5 was aggressive toward him. R74 stated he did not want to wake up with a knife to his throat. Staff instructed R5 to stay away from R74. Interdisciplinary team (IDT) comments dated 12/13/17, on Resident Incident Report indicated offered different room, put on list well checks alcohol behavior. Resident Incident Report section on potential vulnerable adult issue was blank. The record lacked evidence of an investigation following the incident.

2/22/18, indicated R74 was struck by R5 with a closed fist when R74 told R5 not to touch a staff member. IDT comments dated 2/23/18, on Resident Incident Report indicated offered different room, resident refused assist with calling police if needed. Resident Incident Report section on potential vulnerable adult issue was blank.The record lacked evidence of an investigation following the incident.

4/15/18, indicated R74 reported to staff, his side really hurt and said, "I don't need to put up with this pain." R74 showed staff two purple bruises under his left breast approximately two centimeters in diameter. When asked how he got the bruises R74 said, "My Room mate." IDT comments dated 4/23/18, on Resident Incident Report indicated monitor bruises until healed. Resident Incident Report section on potential vulnerable adult issue was blank. The record lacked evidence of an investigation following the incident.

4/24/18, at 1:30 p.m. indicated R74 made verbal threats toward staff. Police were called and spoke with R74. a second Resident Incident Report at 8:20 p.m. indicated staff witnessed R48 run toward R74 yelling at him to leave. R48 then shoved R74 against the wall causing him to slip

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32000	Continued From page 19 and nearly fall. Back of Resident Incident Report blank. Suspected Substance Abuse form attached to the Resident Incident Reports and indicated R74 admitted to having a few drinks. All forms were attached to each other. IDT comments dated 4/25/18, on Resident Incident Report dated 4/24/18, at 1:30 p.m. indicated, "30 day notice, 911 hospital Left AMA[against medical advice], came to facility & [and] left gain 2 [secondary to] police escort." signed by the DON Resident Incident Report section on potential vulnerable adult issue was blank. The record lacked evidence of an investigation following the incident. During interview on 5/23/18, at 2:06 p.m. the director of nursing (DON) stated the incident on 2/22/18, was not reported to the SA but was reported to the police. The DON stated, looking back, she did not know why a report was not made to the SA. She stated she did not believe R5 wanted to hurt R74 and was being protective of the staff. In regard to the incident on 4/15/18, the DON stated it was not reported to the SA because the bruises were not injuries of unknown origin. She stated the interdisciplinary team met and discussed the incident and determined it was not reportable. She indicated R74's bruising was related to a medical diagnosis that affected his clotting time and stated, he had bruises. In regards to the incident on 4/24/18 of R74 being shoved into the wall by R48 the DON stated she had never seen that R74 had been shoved on that until reviewing incident reports with surveyor. DON stated the incident of R48 shoving R74 into the wall should have been reported. The DON stated there was no additional investigation but the information that was on the Resident Incident Reports. the DON stated if the incidents had been reported, a more detailed investigation would	32000		

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32000	Continued From page 20 have been completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	32000		