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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S7NJ

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 **09/05/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
CCN-24 E185--Facility's request for continuing waivers involving tag 0458 (Bedrooms measure at least 70 sq ft) has been approved.

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 09/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/20/2017 (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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 24E185

September 20, 2017

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 August 26, 2017 the above facility is certified for:

98 Nursing Facility II Beds

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

Your request for waiver of F458 has been approved based on the submitted documentation.

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 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
September 20, 2017

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

RE: Project Number SE185026

Dear Ms. Thorson:

On August 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 19, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 5, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 19, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 26, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 19, 2017, effective August 26, 2017 and therefore remedies outlined in our letter to you dated August 7, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under F458 at the time of the July 19, 2017 standard survey has been approved.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@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: S7NJ

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 **07/19/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B, 9** (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):
Facility's request for a continuing waiver involving tag F458 (bedrooms measure at least 70 sq ft) has been recommended to CMS.

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 08/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/13/2017 (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

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: S7NJ

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

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To (b) :

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

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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___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
X 9. Beds/Room

* Code: **B, 9** (L12)

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Facility's request for a continuing waiver involving tag F458 (bedrooms measure at least 70 sq ft) has been recommended to CMS.

17. SURVEYOR SIGNATURE — Date : 08/15/2017 (L19)
Magdalene Jares, HFE NE II

18. STATE SURVEY AGENCY APPROVAL — Date: 09/13/2017 (L20)
Kamala Fiske-Downing, Enforcement Specialist

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

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

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

26. TERMINATION ACTION: (L30) **00**
VOLUNTARY
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 9/14/17 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 7, 2017

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

RE: Project Number SE185026, HE185043

Dear Ms. Thorson:

On July 19, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 19, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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 a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 August 28, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 October 19, 2017 (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 January 19, 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 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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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
	24E185	A. BUILDING _____ B. WING _____	07/19/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on 7/17/17, through 7/19/17, and a complaint investigation was also completed at the time of the standard survey. An investigation of complaint, HE185043 was completed. The complaint was found to be unsubstantiated The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		8/26/17

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

Electronically Signed | 08/15/2017

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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	24E185	A. BUILDING _____ B. WING _____	07/19/2017

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

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F 323	Continued From page 1 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain informed consent and provide a risks and benefits for the use of mobility bars/side rails for 2 of 2 residents (R23, R76) reviewed for accidents Findings include: On 7/17/17, at 1:44 p.m. during the room tour and interview, R23 was observed sitting on the edge of the bed with a grab bar affixed to the bed was next left side. When approached, the resident stated she had asked the staff several time to turn her mattress over because she sat on the edge by the grab bar and over time the mattress had gotten so thin. At that time, the resident stood up and as she stood up, R23 was observed to grab onto the grab bar. The grab bar was observed to be loose and bent inward approximately two inches as the resident stood. R23 was observed to have unsteady balance as she stood slowly off the bed. When asked about the grab bar, she stated she used it all the time as she had two strokes now in the past and had	F 323	Initial comments Please accept the following as the Facility□s credible allegations of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the Facility□s admission of non-compliance with any State or Federal standard, requirements or regulations. F 323 The facility provides resident with an assistive device that promotes independence in bed mobility, transfers and assistance with maintaining their highest level of physical and psychosocial well-being. Prior to application for the bed mobility device the facility will complete an assessment, review for risk benefit and consent with resident or guardian. The facility has developed a Bed Mobility	

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F 323	Continued From page 2 gotten more unsteady with time. When asked if the staff had given the consent for the grab bar to be installed to the bed and if the risks and benefits were explained to her, LR23 stated she did not know. Review of the Incident Log revealed R23 had falls on 7/31/16, 12/25/16, 1/15/17, and 1/22/17, in the room when she was transferring without her ankle and foot orthosis (AFO) brace; reaching for an item, had lowered herself to floor, and had indicated was dizzy and fell from bed respectively. The medical record lacked evidence for a consent for the use of the device had been obtained prior to installation and if the risks and benefits of the side rail/mobility bar/grab bar had been provided to R23. R23's care plan reviewed 5/10/17, indicated resident was at risk for falls related to right sided cerebrovascular accident (CVA) and osteoporosis. The care plan identified R23 was not always steady with transitions and had a mobility bar on the bed for bed mobility. R23's diagnoses included age related nuclear cataract, restless leg syndrome, hemiplegia, hemiparesis and anxiety obtained from the quarterly Minimum Data Set (MDS) dated 5/18/17. In addition, the MDS indicated resident had intact cognition, had both upper and lower extremity impairments and was nor steady with surface to surface transfer which included walking, moving from seated to standing position and walking. The care plan review assessment dated 5/18/17, indicated resident ambulated independently, was unsteady with ambulation and transitions, but did	F 323	Device Policy and Bed Mobility Device Utilization Tool. The tool contains assessment related to entrapment, risk benefits/consent and appropriateness of the bed/mattress. R23 was assessed using new Bed Mobility Device Utilization Tool and IDT met with review of resident□s wishes, device appropriateness and safety without concern. Use of the device was communicated to the resident Primary Medical Doctor and orders verified. R23 could demonstrate use of the Bed Mobility Device and it was verified to be included on her care plan. R76 was assessed using new Bed Mobility Device Utilization Tool and IDT met with review of device appropriateness and safety with concern. R76 was not able to transfer or follow one step directions to utilize the Bed Mobility Device. Due to concern the Bed Mobility Device was removed from R76s bed. The removal of the device was communicated to the resident□s daughter due to lack of cognition and the Primary Medical Doctor was updated. The use of the Bed Mobility Device was removed from her care plan. A facility wide audit of current Bed Mobility Device was conducted with 14 residents identified to have devices, this includes R23 and R76. Licensed staff completed Bed Mobility Device Utilization Tool, interview with risk benefits and demonstration of use by current residents. IDT met and reviewed policy and data to	

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F 323	Continued From page 3 not require hands on assist. R23's Physician Order Summary Report dated 6/22/17, indicated resident had an order which indicated "Siderail: OK for ½ side rail for mobility." On 7/18/17, at 3:33 p.m. registered nurse (RN)-A stated she had never completed a mobility bar, grab bar or side rail assessment for any resident. She stated she was not sure what kind of device R23 had in the bed and had to go look. When asked if a consent and the risks vs. benefits had been provided to R23, she stated she would not know where that information would be and would have to ask other staff. RN-A stated all the assessments were completed in the computer and none had been completed for R23. RN-A also stated she thought maintenance is supposed to keep a log of all the mobility bars being checked for proper function. On 7/18/17, at 3:43 p.m. the maintenance director went to room with surveyor stated the mobility bar was designed that way and had to have some movement when being used but was not able to answer if the inward bending was appropriate. He indicated he checked it weekly and monthly because resident used it a lot more than other residents during his rounds and the last time he had checked it according to the Maintenance Weekly Mobility bar/Side rail log on 7/3/17. On 7/18/17, at 3:51 p.m. RN-A stated "we do not have an actual assessment for grab bars or mobility bars, we do not provide consent and risks vs benefits." RN-A acknowledged the revised regulation implemented 11/28/16, regarding devices had not been implemented by	F 323	ensure that current use was appropriate. As appropriate consent and risk benefits were provided for families or guardians. Orders and care plans reviewed. Ongoing review will occur quarterly and with significant change and reviewed during care conferences. Education was provided to Licensed Nursing staff and IDT members regarding the use of the Bed Mobility Device Utilization Tool and Policy. The facility will review all new request for Bed Mobility Device per the policy. Maintenance will continue to complete the weekly mobility bar/ side rail, roll back safety check to ensure that current Bed Mobility Devices are properly installed and maintained. Safety committee reports will be reviewed and presented to QAPI quarterly for 6 months then ongoing as needed. Continued compliance will be the responsibility of the director of nursing. Date certain for compliance 8/26/17.	

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F 323	Continued From page 4 the facility. On 7/19/17, at 1:04 p.m. the director of nursing (DON) stated regarding the mobility or side rails "we do not assess them, we don't consider them restraints, we don't provide consent or risks vs benefits and we have no policy at this time." R76's bed was observed on 7/17/17, at 4:08 p.m. The mobility bar was observed to be loose, surveyor was able to move the mobility bar from head to foot of the bed and was not secured to the bed. R76's diagnoses included dementia, generalized anxiety disorder and spinal stenosis obtained from the annual MDS dated 6/20/17. In addition, the MDS indicated R76 had severe cognitive impairment, required two-person extensive assist with bed mobility and required total dependence for transfers to and from bed, chair, wheelchair and standing. R76's fall Care Area Assessment (CAA) dated 6/20/17, indicated R76 had the potential for falls related to difficulty maintaining sitting balance, impaired balance during transitions and antipsychotics. R76's care plan dated 6/21/17, indicated resident was at risk for falls related to use of psychotropic medications, unsteady gait and impaired mobility and dependence on staff for all mobility needs. The care plan directed staff to assist with transfers and bed mobility. In addition, the care plan indicated R76 was unsteady with transitions from a seated to standing position and was dependent for assistance to stabilize self with mobility for safety, transfer bar to left side of bed	F 323		

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F 323	Continued From page 5 and using sit-to-stand lift with transfers. On 7/18/17, at 3:53 p.m., when the loose mobility bar concern was brought to the DON, she stated "it shouldn't be," she further stated resident used it for rolling side to side and did not use it to get up on her own because R76 used a sit to stand for transfer. On 7/18/17, at 4:03 p.m., during a follow up interview with the DON regarding R76's loose mobility bar, she stated "I am going to get the maintenance guy to fix it." On 7/19/17, at 1:38 p.m., the DON stated the facility did not have a policy for use of mobility bars, grab bars or side rails, there were no assessments done and residents were not given consents prior to application of device and risks and benefits. She also stated "we don't consider them a restraint." When asked about R76's mobility bar she stated maintenance checked it and had tighten it.	F 323		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility;	F 425		8/26/17

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F 425	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure medications were available and administered as prescribed by the physician, for 1 of 1 resident (R90) whose medication was unavailable at prescribed administration times. Findings include: R90's diagnoses included anxiety disorder, depression, schizophrenia, post-traumatic stress disorder and borderline personality disorder obtained from the quarterly Minimum Data Set (MDS) dated 5/4/17. In addition, the MDS indicated R90 had intact cognition and had delusions and hallucinations. On 7/18/17, at 2:00 p.m. during review of the July 2017, medication administration record, it was revealed R90 had an order dated 7/14/17, for Clozapine (antipsychotic medication used for schizophrenia) 25 milligram (mg) by mouth every noon which was an increase to the current scheduled dose, however, the medication had not been given for four days 7/15/17, 7/16/17, 7/17/17, and 7/18/17. The staff had their initials circled and under the initials was "Not available [N/A]." On 7/19/17, at 1:23 licensed practical nurse (LPN)-B stated on 7/14/17, when the order was written by the doctor she had faxed the order to Omnicare pharmacy. However, when she worked next on the floor 7/17/17, she realized she had faxed it to the wrong pharmacy and the medication was not available. LPN-B then stated on 7/17/17, she faxed the order to Genoa	F 425	F425 The facility works with pharmacy to provided medications per physician orders in a timely manner and maintain an adequate supply. R90 received her supply of clozapine from the specialty pharmacy prior to the end of the survey. The facility will continue to support that medications are provided by obtaining labs, updated to physician and accurate orders. Nursing management completed the end of July medication audits. Identified medications that currently are on hold, awaiting prior authorization or resident purchase were addressed. The facility will work with each resident, guardian and primary physician to identify and resolve the issue. The facility developed a Missing Medication Policy and Procedure to direct staff in the timely resolution of issue. The missing medication memo will be completed by the licensed staff and trained medication assistants (TMA). The memo directs the nurse to call the pharmacy, identify the reason for non-delivery, update the MD and alert the director of nursing to event. Weekly audit by nursing administration to identify compliance will be reviewed at Nursing/TMA meetings and on an individual basis.	

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F 425	Continued From page 7 pharmacy and a pharmacy staff had called back on Monday 7/17/17, and stated they would not fill the medication because the doctor had to send a prescription or give a telephone order. Also, the pharmacy staff stated they would contact the doctor. LPN-B verified even though the order had been written on 7/14/17, the medication was not given during the weekend and two days after. When asked if she was aware the medication was not available, LPN-B stated on the weekend she was the building charge and had not made it to the floor as the trained medication aide (TMA) passed medications. When asked when the medication was delivered she stated around 3:00 p.m. on 7/19/17. When asked why the medication was not given after it had been delivered TMA-C stated she was getting ready to count medications with the next shift and did not think of giving it "Am sorry I did not think of it. I should have given it." On 7/19/17, at 1:50 p.m. when asked if she had contacted the doctor about medication not being available and not administered, LPN-B stated she would have charted it and did not recall contacting the doctor through the e-mail and did not think the director of nursing (DON) either had contacted the doctor. LPN-B stated she had not worked on 7/18/17, when medication had been delivered and not given. LPN-B stated under professional standards the nurse should have called the MD and asked if to give the medication as it was past the time as doctor knew about resident anxiety. LPN-B stated "it's an omission. I will make copies to fill an incident report." On 7/19/17, at 2:01 p.m. when approached and asked about her medications, R90 stated she had missed Clozapine for the past weekend and had	F 425	Monthly reports will be reviewed by administrator, director of nurses and medical director. Reports will be presented to QAPI quarterly for 6 months then ongoing as needed. Continued compliance will be the responsibility of the director of nursing. Date certain for compliance 8/26/17.	

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F 425	Continued From page 8	F 425		

just been given the first dose that day 7/19/17. When asked how she felt the resident indicated she was happy she was getting the medication again at noon.

On 7/19/17, at 2:11 p.m. the director of nursing (DON) acknowledged the medication should have been faxed to the right pharmacy in the first place when the order had been written, when the concern had been identified would have expected the nurse to notify the doctor and fax the order to the right pharmacy. DON acknowledged resident had missed the medication for four days "that is a big medication." DON stated the doctor should have been called to let him know medication was not available during the weekend and that resident had missed the medication ordered and when medication was delivered on 7/18/17, at 3:00 p.m. that the dose for that day had not been given. DON stated the doctor must have known the medication had not been available from the pharmacy when obtaining the prescription however, would have expected the nurses to initiate the concern. DON further stated she had not contacted the doctor as LPN-B was not sure if she had.

On 7/19/17, at 2:24 p.m. the doctor was called about the concern however no call back during the survey.

The facility policy and procedure for ordering medication dated 11/2012, indicated "It is the policy of Bywood East Health Care to have medications ordered by the physician available for residents' use." In addition, the policy directed "Schedule II medications will be ordered on a timely basis to enable delivery prior to running out. This will include both routinely ordered

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F 425	Continued From page 9 scheduled II and [as needed] PRN medications. Medpasser will be responsible for pulling the stickers and faxing orders to the pharmacy..."	F 425		
F 458 SS=E	483.90(e)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT (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: 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	F 458	Please refer to attached letter for waver	8/26/17

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F 458	Continued From page 10 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 and room 309 was empty at the time of the survey.	F 458		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize a system to monitor, report and repair unsanitary conditions in areas used by residents and visitors. This had the possibility of affecting all of the residents residing in the facility. Findings include:	F 465	F465 It is the goal of the facility to maintain all areas in a clean and sanitary manner. Room 101 carpet was cleaned on 8-11-17. In Room 206, brown liquid was cleaned on 7-19-17. The caulking by sink has been replaced. Room 214 wall was cleaned on 7-19-17.	8/26/17

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F 465	Continued From page 11 During the environmental tour on 7/19/17, at 7:36 a.m. with the director of maintenance and the head housekeeper, environmental concerns were identified and confirmed in multiple resident rooms and in adjacent areas: -The doorway of room 101, an area approximately four inches by six inches of carpeting was heavily worn and stained black. -Room 206, two inches of caulk were missing on the right side of the sink and three drops of dried brown liquid were on the wall near the right side of the sink. -The wall in room 214 had a dried, yellow substance approximately four inches in diameter with three areas of drip below. This was approximated three feet above the floor. -The sink in room 302 had four inches of caulk missing on the left side the sink. The faucet handles in the sink were mismatched: the cold water handle in the sink was six inches in length, the hot water handle was two inches in length. -The carpeting in the south stairwell had black stains on 4 of the stairs in between the second and third floor. -The fourth step from the top of the stairs in the north stairwell was a black stain ten inches long and two inches wide. -The back wall of the tub in room 107 had one foot of caulk missing. The same area of the tub had an eight-inch line of a black substance the director of maintenance identified as mold. A line of this same substance also extended six inches up the right corner of the tub. -The back wall of the tub in room 109 had most of caulk missing and a 12-inch line of a black substance the director of maintenance identified as mold. In the shower area, the shower wall panel was missing trim on the upper edge, which exposed a raw edge and allowed the upper area	F 465	The caulking by sink in room 302 has been replaced. The carpet in the stairwell was shampooed on 8-11-17. Room 107 mold was treated and removed on 7-19-17 per CDC guidelines. The caulking was completed on 7-20-17. Room 109 mold was treated and removed on 7-19-17 per CDC guidelines. The caulking was completed on 7-20-17. All resident rooms in the building were checked for the presence of mold on 7-19-17. Any additional mold noted was remediated that day, and steps taken for prevention. All resident rooms in the building were checked for cleaning needs on 8-15-17 and to see whether the deep cleaning schedule is being adequately performed. Results reviewed with housekeeping department members in a meeting on 8-15-17, and re-training provided on various matters pertaining to cleanliness and to reporting anything that is not to our standards to Maintenance for follow up. The Orientation checklist will be developed by 8-24-17 to be signed by the new orientees and the supervisor and put into their personnel file going forward. All staff will be in-serviced on August 16 & 17 regarding the importance of reporting anything that is not in good repair to Maintenance.	

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 _____	07/19/2017

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

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F 465	Continued From page 12 of the panel to be pulled two inches away from the wall. The toilet in the same room was plugged with what appeared to be toilet paper and stool. On 7/19/17, at 8:23 a.m. the administrator stated she expected housekeeping staff to wipe up the splatters on the wall. She expected the maintenance department to monitor resident areas and complete the needed repairs. In addition, she stated the housekeeping staff was not trained to look for lack of caulk, this was done by the maintenance department. On 7/19/17, at 9:10 a.m., the head of housekeeping stated that she trains newly hired house-keeping staff for two days, using the Deep Cleaning Quality Checklist as a teaching tool. She did not provide documentation of actual staff training. She also stated she used a calendar to identify the deep cleaning/wash schedule for each resident room and after the assigned room was cleaned, the head housekeeper expected the staff to sign the Deep Cleaning Quality Checklist and leave it on her desk. The Deep Cleaning Quality Checklist directed housekeeping staff to check caulk in resident rooms and to list all needed repairs on a blue slip. On 7/19/17, at 9:05 a.m., the maintenance director stated his department was responsible to monitor resident areas and he had not done the repairs. He stated he did not have a schedule for monitoring damage in the resident areas. The maintenance director further indicated if any staff identified a damaged area, they had been instructed to fill out blue repair request forms and put them in the box by the time clock in the	F 465	To monitor, the Administrator will check deep cleaned rooms the following morning using the turned in Deep Cleaning Quality Checklist to check for discrepancies during daily rounds. Monthly, the Maintenance Director will round each room and check for un-reported Maintenance issues. Monthly reports will be reviewed by administrator, director of maintenance. Reports will be presented to QAPI quarterly for 6 months then ongoing as needed. Continued compliance will be the responsibility of the administrator. Date certain for compliance 8/26/17.	

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 _____	07/19/2017

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

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F 465	Continued From page 13 basement which he then either completed the task or delegated it to another staff and after the task is completed, work was documented and slip was saved. During review of the Repair Request slips from 1/6/17 to 7/20/17, it was revealed there no notation of caulking or other identified and verified concerns from the environmental tour with director of maintenance and head housekeeper in any of the slips.	F 465		

BYWOOD EAST HEALTH CARE

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

August 9, 2017

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, MN 55904-5506

Dear Mr. Nederhoff,

Bywood East Health Care respectfully requests a waiver of Federal requirement F458 for the following rooms: 101,102, 107, 108, 109, 202, 208, 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

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 _____	**07/25/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 25, 2017. At the time of this survey, Bywood East Health Care was found 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. 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 85 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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