DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 31, 2022

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

RE: CCN: 24E185
Cycle Start Date: March 28, 2022

Dear Administrator:

On February 23, 2022, we notified you a remedy was imposed. On March 28, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 18, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 10, 2022 be discontinued as of March 18, 2022. (42 CFR 488.417 (b))

In our letter of February 23, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 10, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2022

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

Re: Reinspection Results
Event ID: 5IPC12

Dear Administrator:

On March 28, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 7, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Electronically Submitted
February 23, 2022

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

RE: CCN: 24E185
Cycle Start Date: February 7, 2022

Dear Administrator:

On February 7, 2022, survey was completed at your facility by the Minnesota Department of Health 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.

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

REMOVAL OF IMMEDIATE JEOPARDY

On February 2, 2022, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of E.

Also, on February 7, 2022, the situation of immediate jeopardy to potential health and safety cited at F886 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 10, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see

electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 10, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 10, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 10, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 August 7, 2022 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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 _____	02/07/2022

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 On 2/1/22 through 2/7/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. Additionally, a COVID-19 Focused Infection Control survey was conducted to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The survey resulted in 2 immediate jeopardies (IJ)'s to resident health and safety. The first IJ at F880 began on 2/1/22 when staff failed to wear and discard appropriate personal protective equipment while performing cares on COVID-19 residents and then provides cares immediately after, to COVID-19 negative residents.The facility administrator and director of nursing (DON) were notified of the IJ on 2/1/22 at 6:43 p.m.. The IJ was removed on 2/2/22 at 2:34 p.m.. The second IJ at F886 began on 12/15/21, when the facility failed to test all residents immediately after a COVID-19 outbreak was discovered, according to the Center for Disease Control (CDC) guidelines. The administrator, and director of nursing (DON) were notified of the IJ on 2/4/22 at 1:19 p.m.. The IJ was removed on 2/7/22 at 12:39 p.m.. The above findings did not constitute Substandard Quality of Care; therefore NO extended survey was conducted. The following complaints were found to be SUBSTANTIATED: HE185156C (MN51756), HE185166C (MN55761), HE185167C	F 000		

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

Electronically Signed | 02/28/2022

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

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F 000	Continued From page 1 (MN56178), and HE185172C (MN57869), HE185186C (MN61864), and HE185191C (MN62646). However, due to actions taken by the facility prior to the survey, NO deficiencies were cited. The following complaints were found to be SUBSTANTIATED: HE185155C (MN51624), with a deficiency cited at F842, and HE185159C (MN70409) and HE185160C (MN68814) with a deficiency cited at F880. The following complaints were found to be UNSUBSTANTIATED: HE185151C (MN49535), HE185152C (MN79905 and MN79908), HE185153C (MN49770), HE185154C (MN50861), HE185156C (MN51756), HE185157C (MN52845 and MN52720), HE185158C (MN53071), HE185161C (MN53084), HE185162C (MN53388), HE185163C (MN54501 and MN54448), HE185164C (MN55709), HE185165C (MN67581), HE185168C (MN56271), HE185169C (MN58098), HE185170C (MN67202), HE185173C (MN59204), HE185174C (MN64905), HE185175C (MN59693), HE185176C (MN64003), HE185177C (MN59867), HE185178C (MN60394), HE185179C (MN61239), HE185180C (MN63964), HE185182C (MN61307), HE185183C (MN63315), HE185184C (MN61576), HE185185C (MN61788), HE185187C (MN61891), HE185188C (MN61926 and MN61930), HE185189C (MN62034), HE185190C (MN62307), HE185192C (MN62968), and HE185193C (MN49897). The following complaints were found to be	F 000		

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F 000	Continued From page 2 UNSUBSTANTIATED: HE185171C (MN65990) and HE185181C (MN63452), however a related deficiency was cited at F842. 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. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		3/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 3 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 4 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all 86 residents' medical records were maintained accurate, complete, and readily accessible from the time of admission up to 5 years from the date of discharge in accordance with federal regulation with regard to incidents and infection control surveillance. Findings include: Review of R9, R11, and R17's incident reports identified: 1) R9's allegation of abuse was reported to have occurred on 9/4/20, at 2:37 p.m. 2) R17's abuse incident occurred 9/9/19, at 5:00:00. 3) R37's abuse incident occurred 7/24/20, at 17:00:00. There was no mention in the above residents' investigations were documented or maintained in the residents' medical records. Upon interview on 2/3/22 11:16 a.m., the DON indicated the process is to document in the medical record about the incident and the DON did not know why there were no notes in the medical records for these incidents. The DON further indicated the expectation would be to at least have a note for follow up from social services to discuss the event, which was not present for these residents.	F 842	1. Safety: How were the residents affected by the action made safe? R9: documentation was not maintained in the resident s medical records regarding OHFC investigations. R9 was not in this building during the above stated time period, 9/4/2020. She was discharged from our facility on 7/15/2020 and readmitted on 10/15/2020. She was sent to HCMC on 7/8/2020 and was sent to a TCU facility at discharge from the hospital. R37: On 7/24/20, The investigation revealed that there was no contact made between the residents involved in the investigation. R17: On 9/09/2019, Staff was suspended for offensive speech toward resident, which was not charted in the resident s medical record as such. Social services did follow up on the resident s allegation that She is no longer a resident of this facility and the staff person is no longer employed here. From this point forward, it shall be our policy to maintain all of the investigation files for a minimum of five years. 2. Who could be affected by this practice: All residents have the potential to be affected by this alleged deficient practice.	

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F 842	Continued From page 5 During an interview on 2/3/22 at 2:49 p.m., the Infection Preventionist (IP) identified 2 staff members (registered nurse (RN)-D and dietary aide (DA)-A tested positive for COVID-19 on or around 12/15/21. There were approximately 9 more staff since that time who also tested positive, including the administrator. The IP kept no documentation to show what staff or the dates they tested positive as she shreds all documents after Quality Assurance Performance Improvement (QAPI) committee meetings. She stated the last meeting was held on 1/31/22. Review of the QAPI meeting minute notes for January 2022, identified "per our protocols, QAPI investigation materials and records are destroyed once QAPI committee has review...". The minutes also made no mention of any staff having been found positive for COVID. Review of the Vulnerable Adult Abuse Prevention Policy revised 6/18/21, identified: 1) The facility shall make reasonable efforts to determine the source of the suspected mistreatment and take corrective action consistent with the investigative findings to eliminate any on-going danger to the residents. 2) The investigation shall include interviews of the involved resident, family members if appropriate, interdisciplinary staff as appropriate, and any others who may have pertinent information about the event. 3) Records of investigations and corrective actions are maintained by the facility for seven years.	F 842	3. What measures will be put into place to ensure this deficiency does not reoccur. The vulnerable adult policy and procedure will be updated as needed to reflect the current practice 4. What auditing will occur to ensure compliance with this plan?	
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/18/22

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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 6 §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, 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:	F 880		

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	24E185	A. BUILDING _____ B. WING _____	02/07/2022

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F 880	Continued From page 7 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19 to prevent or minimize the transmission of COVID-19 related to use of personal protective equipment (PPE) and the disinfection of multi-resident use equipment from a known COVID-19 positive residents' (R47 and R25) room (Room 1) to a non-COVID-19 positive residents' (R7 and R46) room (Room 2). The	F 880	An ICP consultant from Zellner Consulting has been contracted as of 3/8/22 to meet the requirements of the Directed Plan of Correction. On 3/8/22 the ICP consultant reviewed the DPOC before it was submitted for approval by MDH DPOC Cohorting Residents/Transmission Based Precautions Isolation We will review/revise our policies and procedures regarding Transmission based precautions with ICP consultant.	

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F 880	Continued From page 8 facility's failure resulted in an Immediate Jeopardy (IJ) situation for all 38 residents who resided on the locked housing unit. In addition, the facility also failed to perform active, ongoing surveillance to track and trend all infections, in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guideline for COVID-19. This had the potential to affect all 86 residents in the facility. The IJ began on 2/1/22 at 2:50 p.m., when nursing assistant (NA)-A entered Room 1 with a cart containing multi-resident use equipment (blood pressure cuffs, thermometer, and pulse oximeter). NA-A entered the room without putting on appropriate PPE. NA-A wore a surgical mask, gloves, and eyewear. NA-A took vital signs then exited the room without removing her PPE, or performing any hand hygiene, and failed to disinfect the multi-use equipment. NA-A then went into Room 2, wearing the same PPE and performed vitals on those residents, with the contaminated equipment. The facility administrator and director of nursing (DON) were notified of the IJ on 2/1/22 at 6:43 p.m.. The IJ was removed on 2/2/22 at 2:34 p.m., but non-compliance remained at the lower scope and severity level of E, pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: PPE/DISINFECTION OF SHARED EQUIPMENT Review of the current CDC guidelines for COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019	F 880	We currently do not have any residents who require any contact precautions. Should any residents require such care they will immediately confine symptomatic residents and exposed roommates to their rooms and ensure they wear a mask if they must leave their rooms for any reason. All symptomatic residents will be assigned dedicated equipment. When a resident is placed on transmission-based precautions, PPE and signage will be placed outside the room with instructions for use of the PPE and to speak with the nurse before entering the room. The QAPI committee with the ICP will conduct a root cause analysis to determine the reasons for noncompliance. The RCA will then be shared with the governing board. Training and Education Education is provided to residents and their representatives through every monthly newsletter. This newsletter is sent to all residents and their families and representatives and includes current information regarding the facility□s COVID-19 efforts and current CDC guidelines and mandates. Auditing The DON and the IP and Leadership will verify the placement of new admissions to ensure transmission-based precautions are appropriate for the admission and cohorting of residents. We will audit all new admissions. The results of those audits will be reviewed with the QAPI committee quarterly. As we do not admit new residents on a regular basis, auditing	

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F 880	Continued From page 9 (COVID-19) Pandemic, Updated February 2. 2022, recommends health care staff who enter a room of a patient with suspected or confirmed COVID-19 infection should adhere to transmission-based precautions (TBP) and wear not only a facemask, but gown, gloves, and eye protection. Also, dedicated medical equipment should be used when caring for a patient with suspected or confirmed COVID-19 infection. Interview on 2/1/22 at 10:30 a.m., with the infection preventionist (IP) identified there were 4 residents in the facility that tested positive for COVID-19 (R47, R49, R51, and R9). They all lived on the locked unit with 34 other residents. During observation on 2/1/22 at 2:50 p.m., NA-A entered Room 1 with a cart containing multi-resident use equipment (blood pressure cuffs, thermometer, and pulse oximeter). NA-A entered the room without putting on appropriate PPE and only wore a surgical mask, gloves, and eyewear. NA-A took vital signs on both residents, then exited the room without removing her PPE, without performing any hand hygiene, and failed to disinfect the multi-use equipment. NA-A then went into Room 2 wearing the same PPE and performed vitals with the contaminated equipment. Review of the progress notes for the below COVID positive room residents identified on: 1) 1/27/22, R47 was identified as having been tested at the clinic on 1/26/22. R47 tested positive for COVID-19 and was placed on isolation precautions on 1/27/22 after notification from the clinic. R47 was without symptoms (asymptomatic) of COVID-19. R47 was not tested at the facility, even though there was an outbreak.	F 880	will be done on ALL new admissions for the next year and reviewed quarterly for the next year. DPOC Equipment/Environment We corrected the deficient practice by providing the affected residents with dedicated equipment. All residents have the potential to be affected by this practice. The QAPI committee with the ICP will conduct a root cause analysis to determine the reasons for noncompliance. The RCA will then be shared with the governing board. Our policies and procedures regarding dedicated Covid equipment will be reviewed/revised with the ICP consultant. Training and Education has been implemented on our online learning management system and includes a demonstration of competency of the knowledge at the end of the education. DPOC Hand Hygiene All residents have the potential to be affected by the deficient practice. Immediate education for staff was performed, hands washed appropriately, and equipment sanitized per the disinfectant manufactures recommendation at that time. Policies and procedures have been reviewed and updated to ensure that they meet CDC guidance and CMS requirements. All staff have received training in hand hygiene. Audits will be done every day for one week, then weekly for one month and then ongoing weekly. These audits will be	

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F 880	Continued From page 10 2) 1/27/22, staff noted R25 was notified her roommate (R47) was positive for COVID-19. R25 was noted to also be asymptomatic that day, and therefore R25 was never tested for COVID-19 as the facility was not performing outbreak testing and only tested residents when symptomatic. Interview on 2/1/22 at 3:05 p.m., with NA-A stated she did not see the "COVID-19 isolation information" sign posted on the door of Room 1 before she entered it with the multi-resident use cart to take vital signs. NA-A stated she did not perform hand hygiene or change gloves when exiting the room and did not wear a PPE gown prior to entering the room. NA-A also stated she did not disinfect the multi-resident use equipment after obtaining vitals and before leaving Room 1 entering Room 2. During interview on 2/1/22 at 3:18 p.m., the DON identified expectation that staff were expected to wear appropriate PPE. Shared resident equipment was expected to be disinfected following each resident use, and NA-A should not have entered the shared COVID-19 positive room with the equipment cart. NA-A entering Room 2 was a breach in infection control practices. During interview on 2/4/22 at 12:58 p.m., the medical director identified his expectation was facility staff were expected to follow recommended CDC guidance to prevent and limit the spread of infection. He agreed the above observation was a breach in IC practice and could lead to spread of infection. Review of the May 2021, Disinfection of Multi-Resident Use Equipment policy identified nursing equipment items such as blood pressure	F 880	reviewed quarterly in QAPI quarterly. DPOC PPE Staff was immediately corrected on the deficient practice and educated on the proper use of PPE. All residents had the potential to be affected by the deficient practice. The QAPI committee with the ICP will conduct a root cause analysis to determine the reasons for noncompliance. The RCA will then be shared with the governing board. Policies and Procedures for donning and doffing PPE, source control masks, proper use of gowns and standard and transmission-based precautions will be reviewed/revised with the ICP consultant. All staff will be educated on the above-stated updated policies and procedures through our online learning management system which includes and quiz which must be passed at 80% for compliance. Audits of donning and doffing PPE with TBP will be conducted 4 times a week for one week, then twice weekly for one week once compliance is met. Audits will continue weekly. We do not do aerosol-generating procedures in this facility. Use of gowns will be done during outbreaks. These audits will be reviewed quarterly in QAPI. DPOC Tracking and Trending Infection Control Program All residents have the potential to be affected by this alleged practice. The QAPI committee with the ICP will conduct a root cause analysis to determine the reasons for noncompliance.	

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F 880	Continued From page 11 devices and pulse oximeters that were used by more than one resident were to be appropriately cleaned and disinfected before and after use. Hand hygiene was to be performed prior to donning gloves and after cleaning and disinfecting the item. Review of the August 2021, Pandemic Illness Plan policy identified staff were to use gowns, gloves, masks and eye protection for any emerging pandemic illness. PPE USE DURING COVID TESTING Review of the 9/10/21, Center for Medicaid and Medicare Services (CMS) QSO-20-38-NH memo indicated facilities must maintain proper infection control including wearing a NIOSH-approved N95 or equivalent mask, gloves, and gown when collecting COVID-19 specimens. During an observation and interview on 2/3/22, at 1:20 p.m. the IP was administering COVID-19 rapid tests to nursing assistant (NA)-E in her office. NA-E sat at the IP's desk, approximately two to three feet from the IP, while a swab was inserted into NA-E's nostrils. The IP did not wear an N95 mask or gown, according to CMS guidelines, while administering the tests. The specimen was then paired with a timer on a three-tiered cart, with multiple other specimens and timers. When a timer alerted at 15 minutes, the IP turned off the timer and placed the specimen on her desk to read the results. The IP did not wear gloves to handle the specimen. The IP verified that she always administered the COVID-19 tests to staff in her office and did not wear a gown or N95 mask during the process or wear gloves when handling specimens.	F 880	The RCA will then be shared with the governing board. ICP consultant will review/revise policies and procedures, on resident and staff infection tracking. The IP and DON will review the log daily and report any increase in infections in either the resident or staff population to the medical director and/or the state public health agency immediately for guidance. Training and Education The nursing leadership, the DON and administration will be educated on the new system of infection surveillance. All nurses will receive new instruction on completing Infection Assessments before their next shift. The IP, DON and Administration will engage in training related to tracking, trending infection control surveillance for a comprehensive infection control program. This education will be completed by March 18th and documented as such. Daily review of this data will be done by the QA nurse, DON and IP daily. This data will be reviewed quarterly in QAPI.	

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F 880	Continued From page 12 During an interview on 2/4/22, at 8:02 a.m. licensed practical nurse (LPN)-D stated the IP administered the COVID-19 tests in her office and LPN-D had never seen the IP wear a gown or N95 mask when conducting the tests. The facility COVID Testing policy revised May 2021, did not indicate the need for appropriate use of PPE during the administration of the COVID-19 tests. No other policy on proper PPE wear and use during COVID-19 testing was provided. SURVEILLANCE During an interview on 2/3/22, at 2:49 p.m. the infection preventionist (IP) stated the facility resident population had a high incidence of chronic obstructive pulmonary disease (COPD) (often caused from smoking and could result in chronic coughing) and therefore, it was "too difficult" to track residents' signs and symptoms of COVID-19. The IP stated R9 had fallen and was found to have a low oxygen levels. The IP stated "sniffles" was not a symptom of COVID-19 and therefore, although their tests were positive, they were considered asymptomatic. The IP was unable to provide the exact date when the first two staff members tested positive for Covid-19 in December 2021, putting the facility into outbreak status, but documented they would be able to retest on 3/15/22, which was 90 days after their initial positive test. The IP was not performing appropriate outbreak testing and failed to test any residents for COVID according to CMS and CDC. Review of the facility infection surveillance log for	F 880		

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F 880	Continued From page 13 2021 revealed it contained only copies of physician orders for residents on antibiotics. There was no information regarding signs, symptoms, trends, COVID-19 infections, quarantine dates or any other surveillance criteria available for the year 2021. Review of the facility infection surveillance log for 2022 indicated only 3 residents were positive for Covid-19 although there were four. The log only indicated quarantine start dates for two positive residents, no end dates, signs or symptoms, or their onset were listed. The facility Antibiotic Stewardship policy dated 2/1/22, indicated the IP should track and monitor all infections as they occur. No other policy related to IC surveillance was provided by end of the survey. The IJ was removed on 2/2/22 at 2:34 p.m., when it could be verified by observation, interview, and document review, the facility took steps to ensure all nursing staff were educated on appropriate PPE use, performing hand hygiene, appropriately disinfecting multi-resident use equipment, and we re-educated to policies and procedures, and designated multi-use equipment for each resident on COVID-19 isolation. The facility also immediately tested all residents for COVID-19.	F 880		
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their	F 885		3/15/22

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F 885	Continued From page 14 representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to appropriately inform residents, their representatives and family, and staff of a single confirmed infection of Covid-19, by 5:00 p.m. the next calendar day after two staff members tested positive on or around 12/15/21. This had the potential to affect all 86 residents who resided in the facility, their families, representatives, and staff. Findings include: During an interview on 2/3/22, at 12:25 p.m. family member (FM)-A stated although she was R9's guardian, she had not been notified that R9 had a positive Covid-19 test on 1/25/22. FM-A	F 885	1. What actions were taken to ensure resident safety. The Hotline was updated with the current numbers of COVID cased in the building, the residents guardians and contacts were notified. R49 is not named as a resident in the 2567 document. R47 has no family contacts listed and provided none when asked. R9 does not have a guardian. 2. All residents have the potential to be affected by this alleged deficient practice. 3. What measures were put into place to ensure that this deficient practice will not	

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F 885	Continued From page 15 had also never received any notifications that other residents or staff members had tested positive for Covid-19 and the facility had been in outbreak status since mid-December 2021. During an interview on 2/3/22, at 12:55 p.m. resident representative (RR)-A stated the facility's communication was "not the best" and she had not been notified of any staff or residents having a positive Covid-19 test or that the facility was in outbreak status. During an interview on 2/3/22, at 1:00 p.m. RR-B stated she had been notified on 1/25/22, that R48's roommate had tested positive for Covid-19 on 1/24/22, however, RR-B had not been notified of any other residents or staff members that had tested positive before or after 1/25/22. During an interview on 2/3/22, at 1:06 p.m. FM-B stated she had not been notified of any residents or staff testing positive for Covid-19 by email, phone call, or other modes of communication. Around Christmas, FM-B attempted to visit the facility, and was told the facility policy prohibited visitors. FM-B was not informed there was Covid-19 in the building at the time. FM-B was planning to visit the facility the following week, however, because she was Immunocompromised, was concerned knowing there was currently Covid-19 positive residents because "if I got Covid, it would kill me." During an interview on 2/4/22, at 12:10 p.m. the director of nursing (DON) stated a newsletter was sent to resident families every month with a hotline they could call to find out about positive Covid-19 tests among staff and residents in the facility. The facility did not have many visitors and	F 885	reoccur: Notification of Residents, Families, and Representatives of COVID Occurrence Policy and Procedure will be updated and will include posting notices on the doors to alert visitors and vendors. 4.What auditing will occur? A new auditing sheet has been developed that will be used at a minimum weekly, and be presented at QAPI until substantial compliance is met 5. Who will be educated on these new policies and procedures? Leadership will be educated on these new policies, as well as those staff who will implement the procedures, such as the administrative assistant, Infection Preventionist, Administrator, et al.	

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F 885	Continued From page 16 therefore, no sign was posted at the entrance indicating there were positive Covid-19 staff or residents in the facility. The DON also stated if a resident tested positive for Covid-19, their family or representative should have been notified the same day, however, the DON was unaware a notification should have been done by 5:00 p.m. the following calendar day. During an interview on 2/4/22, at 12:58 p.m. the medical director (MD) stated although R49 tested positive for Covid-19 on 1/24/22, R9 on 1/25/22, and R47 on 1/26/22, he was not notified until 1/31/22 and would have expected to be notified sooner. No facility policy regarding the notification of resident families or representatives of Covid-19 positive staff and/or residents was provided.	F 885		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886		3/18/22

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F 886	Continued From page 17 (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in	F 886		

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 _____	02/07/2022

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 886	Continued From page 18 emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all 86 residents and 87 staff were tested for COVID-19 folowing an outbreak regardless, immediately and, if negative, again 5-7 days later. This deficient practice had the potential to affect all 82 non-COVID-19 positive residents, as well as staff, and visitors in the facility. The IJ began on 12/15/21, when a staff member tested positive for COVID-19 and the facility failed to offer or conduct tests for COVID-19 for all residents, according to Center for Disease (CDC) guidelines. The Administrator and director of nursing (DON) were notified of the IJ on 2/4/22, at 1:19 p.m. The IJ was removed on 2/7/22, at 12:39 p.m. when the facility implemented interventions to ensure all residents were offered or given tests for COVID-19 however, noncompliance remained at the lesser level of F which indicated no actual harm with potential for more than minimal harm that was not an IJ. Findings Include: Review of the 9/10/21, Centers for Medicare and Medicaid (CMS) QSO-20-38-NH memo identified facilities were to conduct testing in a manner that was consistent with current standards of practice for COVID-19 testing. For each instance of testing: Document that testing was completed and the results of each staff test; and document	F 886	1. All residents had the potential to be affected by the deficient practice. All residents were immediately tested for COVID-19 at the rate prescribed by the County Positivity Rate. All residents and staff will be tested per our Covid testing policy should there be any outbreaks in the future. 2. Reviewed policies and procedures, implemented new testing surveillance measures, ordered sufficient amounts of testing supplies to provide for all residents and staff. Educated RN and LPN staff on how to perform COVID testing. All measures included testing on both staff and residents based on the county positivity rate. 3. The QA nurse and the DON will audit the testing surveillance weekly for four weeks following an outbreak period. All auditing will be reviewed at QAPI until substantial compliance is achieved. 4. RN and LPN staff will be educated on how to perform COVID testing. All staff were educated on the need for COVID testing during an outbreak through our online learning management system.	

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F 886	Continued From page 19 in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. The memo identified an outbreak as any new case of COVID-19 in the facility. Upon identification of a single new case of COVID-19 infection in any staff or resident, testing should have begun immediately. Facilities had the option to perform outbreak testing through two approaches, contact tracing or broad-based (facility-wide) testing (when contact tracing was not possible). Interview on 2/1/22 at 10:30 a.m., with the infection preventionist (IP) identified there were 4 residents in the facility that tested positive for COVID-19 (R47, R49, R51, and R9). They all lived on the locked unit with 34 other residents. Review of R47's progress notes identified although the facility had been in outbreak status since 12/15/21, R47 was only tested for COVID-19 at a clinic, prior to her appointment, on 1/26/22. The facility was notified of R47's positive results on 1/27/22. Review of R25's progress notes identified although R25's roommate, R47, had tested positive for COVID-19, and the facility was in outbreak status, R25 had not been offered or tested for COVID-19. Interview on 2/3/22, at 2:49 p.m.with the Infection Preventionist (IP) identified 2 staff members (registered nurse (RN)-D and dietary aide (DA)-A tested positive for COVID-19 on or around 12/15/21. There were approximately 9 more staff since that time who also tested positive, including the administrator. The IP kept no documentation to show what staff or the dates they tested	F 886		

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F 886	Continued From page 20 positive as she shreds all documents after Quality Assurance Performance Improvement (QAPI) committee meetings. She stated the last meeting was held on 1/31/22. The facility had not performed outbreak testing on any resident after any positive diagnosis of COVID. The residents were only tested for COVID if they displayed signs or symptoms she deemed as signs of COVID, or prior to electro-convulsive therapy (ECT) appointments. Roommates of positive COVID residents were not tested for COVID because they were isolated with their positive roommate. The IP was unfamiliar with the CMS QSO-20-38-NH memo that instructed facilities to begin outbreak testing for residents and staff immediately after 1 positive case of COVID was identified through broad-based testing. The facility was unable to conduct contact tracing of the residents due to residents high mobility and movement throughout the building and staff not having set unit assignments. The staff were to be tested twice a week through routine testing due to high COVID county transmission levels; however, if staff were not working on Mondays and/or Thursdays when the IP or DON conducted the COVID tests, or if staff did not choose to be tested, the IP stated she was not going to "chase people down,". "Some will fall through the cracks". Review of the QAPI meeting minute notes for January 2022, identified "per our protocols, QAPI investigation materials and records are destroyed once QAPI committee has review...". The minutes also made no mention of any staff having been found positive for COVID. Interviews on 2/1/22 at 2:00 p.m., through 2/4/22 at 11:00 a.m., with R10, R52, and R53, identified	F 886		

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F 886	Continued From page 21 none of those residents had received any outbreak testing according to CDC outbreak testing guidelines after staff first tested positive in December 2021. Interview on 2/4/22 at 8:26 a.m., with the administrator identified he was unaware how many staff or residents had been diagnosed with COVID. He himself had been diagnosed with COVID recently and had just returned to work. He was unaware how the IP was performing testing or surveillance. He agreed the facility needed to follow CMS and CDC guidance for COVID to prevent further outbreak. Interview on 2/4/22 at 12:58 p.m., the medical director (MD) identified resident and staff testing for COVID-19 should have been conducted according to the CMS guidelines and offered, if not conducted, regularly. Surveillance was also to be performed to track, trend and analyze data to attempt to contain or minimize transmission of COVID throughout the building. Interview on 2/7/22, at 10:12 a.m., RN-D stated residents were only tested prior to going to a clinic appointment even though the facility was in outbreak status. Review of the May 2021, COVID Testing Policy indicated in the event of a COVID-19 outbreak, staff who refused to be tested twice a week would be excluded from work, and residents would be tested every three to seven days. Residents had the right to refuse COVID-19 testing and refusals would be documented in their medical record. The IJ was removed on 2/7/22, at 12:39 p.m. when it could be verified by interview and record	F 886		

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F 886	Continued From page 22 review that the facility reviewed and revised policies and procedures, educated licensed nursing staff on the revised policies and procedures and on how to administer COVID-19 tests, and offered testing to all residents in the facility. The immediacy was removed, and noncompliance remained at the scope and severity of F which indicated no actual harm with potential for more than minimal harm that was not an IJ.	F 886		

Electronically delivered
February 23, 2022

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

Re: State Nursing Home Licensing Orders
Event ID: 5IPC11

Dear Administrator:

The above facility was surveyed on February 1, 2022 through February 7, 2022 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00176	A. BUILDING: _____ B. WING _____	C 02/07/2022

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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: On 2/4/22 to 2/7/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be IN compliance with the MN State Licensure.	3 000		

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

Electronically Signed | 02/28/22

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3 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: HE185155C (MN51624), HE185156C (MN51756), HE185159C (MN70409), HE185160C (MN68814), HE185166C (MN55761), HE185167C (MN56178), and HE185172C (MN57869), HE185186C (MN61864), HE185191C (MN62646). However, due to actions taken by the facility prior to the survey, NO licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: HE185151C (MN49535), HE185152C (MN79905 and MN79908), HE185153C (MN49770), HE185154C (MN50861), HE185156C (MN51756), HE185157C (MN52845 and MN52720), HE185158C (MN53071), HE185161C (MN53084), HE185162C (MN53388), HE185163C (MN54501 and MN54448), HE185164C (MN55709), HE185165C (MN67581), HE185168C (MN56271), HE185169C (MN58098), HE185170C (MN67202), HE185173C (MN59204), HE185174C (MN64905), HE185175C (MN59693), HE185176C (MN64003), HE185177C (MN59867), HE185178C (MN60394), HE185179C (MN61239), HE185180C (MN63964), HE185182C (MN61307), HE185183C (MN63315), HE185184C (MN61576), HE185185C (MN61788), HE185187C (MN61891), HE185188C (MN61926 and MN61930), HE185189C (MN62034), HE185190C (MN62307), HE185192C (MN62968), and HE185193C (MN49897). The following complaints were found to be UNSUBSTANTIATED: HE185171C (MN65990) and HE185181C (MN63452), however a related	3 000		

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3 000	Continued From page 2 licensing order was issued at 655. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software for Minnesota Rules, Chapter 4655 for Boarding Care Homes. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	3 000		
3 655	MN Rule 4655.3600 Storage and Perservation of Records Space shall be provided for the safe storage of patients' or residents' records at the nurses' or attendants' station, a central control point for the storage of records and medications, and in general storage. Records shall be filed so as to be readily accessible. All patients' and residents' records shall be preserved for a period of at least five years following discharge or death. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all 86 residents' medical records were maintained accurate, complete, and readily accessible from the time of admission up to 5 years from the date of discharge in accordance with federal regulation with regard to incidents and infection control surveillance. Findings include: Review of R9, R11, and R17's incident reports	3 655	corrected	3/15/22

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3 655	Continued From page 3 identified: 1) R9's allegation of abuse was reported to have occurred on 9/4/20, at 2:37 p.m. 2) R17's abuse incident occurred 9/9/19, at 5:00:00. 3) R37's abuse incident occurred 7/24/20, at 17:00:00. There was no mention in the above residents' investigations were documented or maintained in the residents' medical records. Upon interview on 2/3/22 11:16 a.m., the DON indicated the process is to document in the medical record about the incident and the DON did not know why there were no notes in the medical records for these incidents. The DON further indicated the expectation would be to at least have a note for follow up from social services to discuss the event, which was not present for these residents. During an interview on 2/3/22 at 2:49 p.m., the Infection Preventionist (IP) identified 2 staff members (registered nurse (RN)-D and dietary aide (DA)-A tested positive for COVID-19 on or around 12/15/21. There were approximately 9 more staff since that time who also tested positive, including the administrator. The IP kept no documentation to show what staff or the dates they tested positive as she shreds all documents after Quality Assurance Performance Improvement (QAPI) committee meetings. She stated the last meeting was held on 1/31/22. Review of the QAPI meeting minute notes for January 2022, identified "per our protocols, QAPI investigation materials and records are destroyed once QAPI committee has review...". The minutes also made no mention of any staff having been found positive for COVID.	3 655		

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3 655	Continued From page 4 Review of the Vulnerable Adult Abuse Prevention Policy revised 6/18/21, identified: 1) The facility shall make reasonable efforts to determine the source of the suspected mistreatment and take corrective action consistent with the investigative findings to eliminate any on-going danger to the residents. 2) The investigation shall include interviews of the involved resident, family members if appropriate, interdisciplinary staff as appropriate, and any others who may have pertinent information about the event. 3) Records of investigations and corrective actions are maintained by the facility for seven years. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 655		