

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

October 8, 2020

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

RE: CCN: 24E185 Cycle Start Date: September 18, 2020

Dear Administrator:

On September 18, 2020, 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 **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

#### REMOVAL OF IMMEDIATE JEOPARDY

On September 11, 2020, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

#### 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 Octuober 7, 2020.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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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 Octuober 7, 2020, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective Octuober 7, 2020, (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 \$11,160; 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 September 18, 2020. 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.

#### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information,

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# you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard guality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bywood East Health Care is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 18, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

# 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" tag), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Bywood East Health Care October 8, 2020 Page 4 Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900 Email: <u>susan.frericks@state.mn.us</u> Mobile: (218) 368-4467

# 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 March 18, 2021 (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

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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

Bywood East Health Care October 8, 2020 Page 6 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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.

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Sincerely,

Kumala R3ke 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: <u>kamala.fiske-downing@state.mn.us</u>



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# DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880: ps://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

#### PERSONAL PROTECTIVE EQUIPMENT (PPE)

• 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.

#### POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

#### TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

• The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

• The training must include competency testing of staff and this must be documented.

• Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.

• Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

#### CDC RESOURCES:

Infection Control Guidance: <u>https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</u>

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CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <u>https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</u>

CDC: Personal Protective Equipment: <u>https://www.cdc.gov/niosh/ppe/</u>

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\_AA\_refVal=https%3A%2F%2Fwww.cd c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

# MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): <u>https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf</u>

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

# MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

# EQUIPMENT/ENVIRONMENT

- 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.

# POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.
- The director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health

care facilities and follow disinfectant product manufacturer directions for use including contact time.

# TRAINING/EDUCATION:

• The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.

Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic\_in\_HCF\_03.pdf
- MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

# CDC RESOURCES:

Infection Control Guidance: <u>https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</u> CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <u>https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</u>

CDC: Personal Protective Equipment: <u>https://www.cdc.gov/niosh/ppe/</u>

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\_AA\_refVal=https%3A%2F%2Fwww.cd c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

# MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

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https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

#### MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

# ACTIVE SCREENING

- 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.

#### POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

• Develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The MDH COVID-19 <u>Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf</u> has examples of forms to utilize for staff screening.

#### TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training must cover the need for active screening. The CDC has training videos available for COVID-19 which may be utilized, Training for Healthcare Professionals; <u>https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html</u> and the MDH COVID-19 Toolkit may be utilized.

• Include documentation of the completed training with a timeline for completion.

• The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

#### CDC RESOURCES:

Infection Control Guidance: <u>https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</u> CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <u>https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</u>

CDC: Personal Protective Equipment: <u>https://www.cdc.gov/niosh/ppe/</u>

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\_AA\_refVal=https%3A%2F%2Fwww.cd c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

# MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19

(PDF):https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

#### MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation

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should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

Attach all items into ePOC.

		HAND HUMAN SERVICES			FORM	10/21/2020 APPROVED
STATEMENT	TOF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATI	E SURVEY
NAME OF F	PROVIDER OR SUPPLIER D EAST HEALTH CA	24E185	A. BUILDIN B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 3427 CENTRAL AVENUE NORTHEAST	EM	C 18/20 <u>20</u>
				MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ITS	F 00	0		
	was conducted 9/1 by the Minnesota I determine complia Control. The facilit compliance.	used Infection Control survey 15/20, to 9/18/20, at your facility Department of Health to unce with §483.80 Infection y was determined NOT to be in of correction (POC) will serve of compliance upon the				
	Department's acce					
		quired at the bottom of the first				
	revisit of your facil substantial compli	acceptable electronic POC, a ity will be conducted to validate ance with the regulations has ccordance with your				
	abbreviated standa your facility by the Health to determin compliance with re	15/20, to9/18/20, an ard survey was completed at Minnesota Department of the if your facility was in equirements of 42 CFR Part and Requirements for Long Term				
	to resident health a on 9/10/20, when the sound in response facility. The facility wanderguard syste enhanced supervise did elope from the	ed in an immediate jeopardy (IJ) and safety. An IJ at F689 began the wanderguard alarm did not a to a resident (R1) exiting the y failed to ensure the em was operational or provide sion of R1. Subsequently, R1 facility. The administrator and				
	Y DIRECTOR'S OR PROVI iically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/09/2020
	ically olyrieu					10/03/2020

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.

STATEMENT	OF DEFICIENCIES	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING _		1B NO. 0938-039 (X3) DATE SURVEY COMPLETED C
24E185 NAME OF PROVIDER OR SUPPLIER BYWOOD EAST HEALTH CARE		ING MOUNI	34	IREET ADDRESS, CITY, STATE, ZIP CODE 127 CENTRAL AVENUE NORTHEAST INNEAPOLIS, MN 55418	09/18/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
	for R1 on 9/17/20 immediately impl 9/11/20, and F68 non-compliance. In addition, an ex 9/18/20, related t findings. Complaint HE185 for past non-com had implemented survey, harm or i sustained prior to Although no plan finding of past not facility acknowled documents. Free of Accident CFR(s): 483.25(d) %483.25(d) Accid The facility must §483.25(d)(1) Th as free of accidea §483.25(d)(2)Ead supervision and a accidents. This REQUIREM by: Based on obserview, the facility wanderguard was	g (DON) were notified of the IJ o, at 11:37 a.m. The facility emented correction action on 9 is being issued at past tended survey was completed o the substandard quality of care 5093 was unsubstantiated, and 6092 was substantiated at F689, pliance. Although the provider d corrective action prior to mmediate jeopardy was o the correction. of correction is required for a on-compliance, it is required the dge receipt of the electronic Hazards/Supervision/Devices d)(1)(2) ents.	F 000	Past noncompliance: no plan of correction required.	10/8/20

Facility ID: 00176

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STATEMENT	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         24E185	(X2) MULT A. BUILDIN B. WING	TIPLE CONSTRUCTION NG	OMB NO. 0938 (X3) DATE SUR COMPLETE C	VEY ED
	AME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 3427 CENTRAL AVENUE NORTH MINNEAPOLIS, MN 55418		1 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOULD BE COM THE APPROPRIATE	(X5) PLETIO DATE
F 689	elopements. This jeopardy (IJ) whe on 9/10/20 and w was found by poli immediately imple corrected the defi issued as past no Jeopardy (IJ). The IJ that began 9/11/20 when the interventions to p administrator and notified of the IJ p at 11:37 a.m., as corrective action Findings include: R1's admission M 7/2/20, indicated dementia, bipolar pulmonary disord cognitive impairm R1 was independ to surface transfe A Brief Interview f most recently cor indicated R1 had A wander risk ass indicated R1 exhi impaired judgeme wandered aimles within the past me	resulted in an immediate n R1 eloped out of the building as missing for 3.5 hours and ice unharmed. The facility emented interventions and icient practice on 9/11/20. This is oncomplaince at Immediate a on 9/10/20 was corrected on facilty implemented revent reoccurance. The I director of nursing (DON) were bast noncomplaince on 9/17/20, a result of the immediate taken by the facility. Aninimun Data Set (MDS) dated R1 had diagnoses that included to depression, chronic obstructive er (COPD), and severe nent. The MDS further indicated ent for ambulation and surface ers. for Mental Status (BIMS) was npleted on 8/21/20, that severe cognitive impairment. sessment completed on 8/19/20, bited behaviors of refusals, ent, impulsive behavior, and had sly within the facility or grounds onth. The assessment further deemed unsafe to leave the	F 68	89		

If continuation sheet Page 3 of 9

STATEMENT	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		1B NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
NAME OF F	PROVIDER OR SUPPLIE	<b>24E185</b>		REET ADDRESS, CITY, STATE, ZIP CODE	09/18/20 <u>20</u>	
BYWOOI	D EAST HEALTH CA	ARE	-	27 CENTRAL AVENUE NORTHEAST NNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD   CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 689	R1's care plan, la	st reviewed 8/18/20, indicated	F 689			
		risk, had a wanderguard alarm deemed unsafe to leave the d.				
	indicated R1 was cigarettes and wo the door alarm. T indicated R1 was	dated 9/10/20, at 9:11 a.m. persistently asking for buld not wait for staff, setting off the progress note further found walking down the alley, and was redirected.				
	indicated R1exite	lated 9/10/20, at 1:23 p.m. d the living room door with a and the alarm did not sound.				
	indicated the mai	lated 9/10/20, at 1:41 p.m. ntenance director (MD)-A was to check the wanderguard on s defective.				
	to MD-A sent on subject that indicate	e food services director (FSD)-B 9/10/20, at 1:44 p.m., had a ated to please check, and furthe t out the living room door and sound.	r			
	R1 had not been around the facility was provided by the facility. Staff s vicinity but were u	dated 9/10/20, at 8:34 p.m. noted seen by any staff member in or / since 3:00 p.m. and no report previous shift about R1 leaving searched for R1 around the unable to find R1. The DON, se manager, and police were				
	indicated R1 was	lated 9/10/20, at 10:53 p.m., brought back by police at about 1 was noted to have no injuries.				

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/21/2020 APPROVED 0938-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
	ENDI	24E185	B. WING	VI ENCEM		C 18/2020
NAME OF	PROVIDER OR SUPPLIER	IU AUM		TREET ADDRESS, CITY, STATE, ZIP CODE 427 CENTRAL AVENUE NORTHEAST	LIN	
BYWOO	D EAST HEALTH CAP	RE		NINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 4	F 689			
	When interviewed R1 e door, and the alarn stated she charted MD-A, asking him if further stated she charted MD-A, asking him if further stated she control is ciplinary action a elopement procedu. When interviewed MD-A stated when working he should call, "anything but a with an urgent issue resort. When interviewed facility administrator finform anyone else properly. The admin 9/11/20, at approxim MD-A reported the had already been conving properly. When interviewed the already been convising properly. When interviewed the administrator finform anyone else properly. The admin 9/11/20, at approxim MD-A reported the had already been convorking properly. When interviewed the key pads and uthat the magnet is a stated the magnet is	on 9/16/20, at 12:09 p.m., exited through the living room in didn't sound. FSD-B further the incident and emailed to check the door. FSD-B did not notify anyone else, but istrator or the DON in the irmed having received and re-education regarding				

Facility ID: 00176

If continuation sheet Page 5 of 9

STATEMENT	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED C
	24E185 IAME OF PROVIDER OR SUPPLIER BYWOOD EAST HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3427 CENTRAL AVENUE NORTHEAST	09	/18/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	MINNEAPOLIS, MN 55418 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	On 9/16/20, at 12 nurse (LPN)-A wa the smoking patie and R1 passed th sounded appropri- When interviewer stated a staff me smoke. R1 further facility. When interviewer trained medicatio residents' wande each shift and the night to make sur- When interviewer nursing assistant received training procedures. NA-/ to the wandergua resident before d When interviewer NA-B stated all si regarding elopern residents were at When interviewer NA-C stated she how to respond if elopes from the f charge nurse wo resident could no When interviewer	<ul> <li>2:07 p.m., licensed practical as observed to escort R1 from p into the facility. When LPN-A prough the door, the alarm iately.</li> <li>d on 9/15/20, at 3:24 p.m., R1 mber goes with him outside to er stated feeling safe at the</li> <li>d on 9/15/20, at 3:31 p.m., n aide (TMA)-A stated all rguard placement was checked e evening supervisor tested each re their wanderguard works.</li> <li>d on 9/15/20, at 3:33p.m., (NA)-A stated staff recently on wanderguard and elopement A further stated all staff respond and elopement A further stated all staff respond and must locate the eactivating the alarm.</li> <li>d on 9/16/20, at 10:07 a.m., taff were recently re-educated performed in the stated all staff respond.</li> <li>d on 9/16/20, at 12:21 p.m., recently received education on fisomeone with a wanderguard acility. NA-C further stated the uld be immediately informed if a</li> </ul>	F 689			

If continuation sheet Page 6 of 9

TATEMENT	OF DEFICIENCIES F CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING		1B NO. 0938-039 (X3) DATE SURVEY COMPLETED C
	E OF PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE 7 CENTRAL AVENUE NORTHEAST	09/18/20 <u>20</u>
				INEAPOLIS, MN 55418	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 689	Continued From	page 6	F 689		
	year, and had red	orking at the facility earlier in the cently read new education nent and how to respond to the rm.			
	LPN-A stated R1 cognitively impair appropriate interv	d on 9/16/20, at 12:29 p.m. had a wanderguard and was red. LPN-A further stated ventions were currently followed for R1 over the past week.			
	DON stated the f placement on res wanderguard fun residents with wa stated if it were n was not working DON, infection pl assistant adminis	d on 9/16/20, at 2:49 p.m., the acility checked wanderguard sidents every shift and ction every 24 hours for inderguards. The DON further oted the wanderguard system the expectation was to notify the reventionist, administrator, or strator immediately. The DON ff should monitor the door or			
	was an issue with DON also stated on 9/10, staff follow and erguard ala and staff did not another resident The DON added missing they sea grounds, called th incident to the St	nonitoring of the resident if there n a residents wanderguard. The i in response to R1's elopement owed the policy when the rm went off around 3:30 p.m., realize R1 had eloped when set off the wanderguard alarm. when the facility realized R1 was rched rooms, the building he police and reported the ate Agency (SA). Finally, the raff had been re-educated on the			
	elopement policy When interviewe administrator sta the administrator				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/21/2020 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN				E SURVEY PLETED
	ENDI	24E185	B. WING _	Λ/I	ENCEN		C 18/20 <u>20</u>
- R.		IA LIAITI	IV)		ADDRESS, CITY, STATE, ZIP CODE		
BYWOO	D EAST HEALTH CAN	KE		MINNE	APOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	С	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI ROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 7	F 68	9			
	versus writing an e	mail to MD-A.					
	Prevention Plan Pc 6/20, indicated it w provide a safe envi policy further indica be assessed as ne wandering prevent	andering / Elopement blicy and Procedure, updated as the policy of the facility to ironment for all residents. The ated the safety care plan would beded to ascertain appropriate ion. The policy further indicated maintenance of any alarm eded repair work.					
	Refresher, dated 9 residents with a wa when the wandergu should check for re- outside the building protocol refresher not turn off the war	d Wanderguard Protocol /11/20, included images of anderguard, and indicated uard alarm sounds, staff esidents on a wanderguard g and around corners. The further indicated staff should nderguard alarm unless they esidents with a wanderguard unted for.					
	9/10/20, was remo facility took the foll and correct the def audit of the wander wanderguard brace ensure they were in 9/11/20, disciplinar regarding equipme maintenance staff wanderguard malfu elopement protoco will check the grou residents with a wa door alarm. All staff	pardy (IJ) that began on ved on 9/11/20, when the owing steps to remove the IJ ficient practice: On 9/11/20, an rguard system, including all elets used, was completed to in proper working order. On y action and re-education int malfunction was provided to and staff that observed the unction. On 9/11/20, the I was updated to indicate staff inds thoroughly and account for anderguard in response to the f were re-educated to the policy and protocol beginning					

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		AND HUMAN SERVICES			FORM	10/21/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
D	ENDI	24E185	B. WING	VI ENCEN	( 09/*	C 18/2020
NAME OF F	PROVIDER OR SUPPLIER	NU AUNIN		STREET ADDRESS, CITY, STATE, ZIP CODE	IEN	<u> </u>
BYWOOI	D EAST HEALTH CAI	RE		3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	confirmed by interv and non-nursing st provided and staff administrative staff	ation of corrective action was view with a variety of nursing aff that verified education was will notify maintenance and f of any possible malfunction of ystem and ensure the	F 689			

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		AND HUMAN SERVICES			FORM	10/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE	E SURVEY IPLETED
NAME OF F	PROVIDER OR SUPPLIER	24E185	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		18/20 <u>20</u>
BYWOOI	D EAST HEALTH CA	RE		3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F 00	0		
	was conducted 9/1 by the Minnesota I determine complia	sed Infection Control survey 5/20, to 9/18/20, at your facility Department of Health to nce with §483.80 Infection y was determined NOT to be in				
		of correction (POC) will serve of compliance upon the optance.				
		nrolled in ePOC, your quired at the bottom of the first 2567 form.				
	revisit of your facili substantial complia	acceptable electronic POC, a ty will be conducted to validate ance with the regulations has ccordance with your				
	abbreviated standa your facility by the Health to determin compliance with re	5/20, to9/18/20, an ard survey was completed at Minnesota Department of e if your facility was in equirements of 42 CFR Part id Requirements for Long Term				
	to resident health a on 9/10/20, when t sound in response facility. The facility wanderguard syste enhanced supervise	d in an immediate jeopardy (IJ) and safety. An IJ at F689 began he wanderguard alarm did not to a resident (R1) exiting the failed to ensure the em was operational or provide sion of R1. Subsequently, R1 facility. The administrator and				
	director's or provi	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/09/2020

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.

	OF DEFICIENCIES	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLI	<b>24E185</b>	B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	09/18/20 <u>20</u>
	D EAST HEALTH C		342	7 CENTRAL AVENUE NORTHEAST INEAPOLIS, MN 55418	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTIO
F 000 F 880 SS=F	director of nursin for R1 on 9/17/20 immediately impl 9/11/20, and F68 non-compliance. In addition, an ex 9/18/20, related to findings. Complaint HE18 complaint HE188 for past non-com had implemented survey, harm or is sustained prior to Although no plan finding of past not facility acknowled documents. Infection Prevent CFR(s): 483.80(a) §483.80 Infection The facility must infection prevent designed to prov comfortable envit development and diseases and infection program.	in (DON) were notified of the IJ b, at 11:37 a.m. The facility lemented correction action on a is being issued at past attended survey was completed to the substandard quality of care 5093 was unsubstantiated, and 5092 was substantiated at F689, apliance. Although the provider d corrective action prior to immediate jeopardy was to the correction. a of correction is required for a con-compliance, it is required the dge receipt of the electronic tion & Control a)(1)(2)(4)(e)(f) in Control establish and maintain an ion and control program ide a safe, sanitary and ronment and to help prevent the d transmission of communicable	F 000		10/9/20

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		AND HUMAN SERVICES			FORM	10/27/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24E185	B. WING		09/ <sup>.</sup>	18/2020
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
BYWOO	D EAST HEALTH CAP	RE		427 CENTRAL AVENUE NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 880	reporting, investiga and communicable staff, volunteers, vi providing services arrangement based conducted accordin accepted national s §483.80(a)(2) Writt procedures for the but are not limited f (i) A system of surv possible communic infections before th persons in the facil (ii) When and to wh communicable dise reported; (iii) Standard and th to be followed to pr (iv)When and how resident; including (A) The type and d depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstan must prohibit emploid contact with reside contact with reside	stem for preventing, identifying, ting, and controlling infections e diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards; ten standards, policies, and program, which must include, to: veillance designed to identify cable diseases or ney can spread to other ity; nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the asible for the resident under the ces under which the facility oyees with a communicable skin lesions from direct nts or their food, if direct	F 880			

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CENTER	RS FOR MEDICA	RE & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	$\mathbf{D}$	24E185	B. WING		09/18/2020
NAME OF F	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP	
BYWOOI	D EAST HEALTH C	ARE		3427 CENTRAL AVENUE NORTHE	ASI
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLÉTION E APPROPRIATE DATE
F 880	Continued From	page 3	F 8	80	
	identified under the facility's IPCP and the corrective actions taken by the facility.				
		ns. handle, store, process, and so as to prevent the spread of			
	IPCP and update This REQUIREN	al review. onduct an annual review of its e their program, as necessary. IENT is not met as evidenced			
	review, the facilit comprehensive i include recomme screening procee equipment and w protective equipm	vation, interview and document y failed to implement a nfection control program to ended COVID-19 staff health dures, disinfection of shared vearing of appropriate personal nent (PPE). This had the t all 77 residents in the facility		Based on observation, inte document review, the facili implement a comprehensiv control program to include COVID-19 staff health scree procedures and wear appre- personal protective equipment the potential to affect all 77 regided in the facility	ity failed to ve infection recommended eening location opriate nent. This had
	Findings include:			resided in the facility Findings include:	
	8:09 a.m until 8: At 8:09 a.m., an observed enterin present at the CC station. The unid own temperature screening sheet building. There w unidentified staff if they had sympt sanitized after us At approximate (NA)-D arrived a	Is observations on 9/17/20, from 19 a.m., the following was noted: in unidentified staff member was g the facility; no staff were DVID-19 symptom screening entified staff member took his twice, filled out a symptom and proceded to enter the vas no screener to ensure the member did not enter the facility toms. The thermometer was not se. ly 8:16 a.m., nursing assistant t the screening desk from hin the facility, and was observed		9/15/20, at 12:45 p.m. Sur Surveyor 2 walked into the S2 signed their names on a they entered the facility. A took temperatures of S1 ar asked staff member if they questions. The staff memb screening questions related but did not write the answe S1 and S2 down on their tr asked the staff member if t to write down S1 and S2 C screening questions. The s proceeded and wrote S1 a	facility. S1 and a form when staff member nd S2. S1 had any ber asked d for COVID 19 ers provided by racking log. S2 they were going OVID 19 staff member

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CENTER	RS FOR MEDICA	RE & MEDICAID SERVICES			ORM APPROVE <u>NO. 0938-039</u>		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		3) DATE SURVEY COMPLETED		
		24E185	B. WING		09/18/20 <u>20</u>		
NAME OF F	PROVIDER OR SUPPLIE	ER	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BYWOOI	D EAST HEALTH C	ARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 880	Continued From	page 4	F 880				
	at screening des entered the build out the COVID-1 on the staff scree temperature with thermometer, sa into the building. disinfected after At 8:19 a.m., lic was observed er surgical mask ar to fill out the staff form, took her ow non-disinfected t temperature on t thermometer was time during the c screening proces disinfected. On 9/17/20, at 8: approach the CC station from insic sunglasses and initially present a screening station temperature and screening form; I table at this time enter the facility. facility from anot station and walk screening station eye protection.	k when social worker (SW)-A ling. SW-A donned a mask, filled 9 symptom screening questions ening form, took her own a the non-disinfected nitized her hands and proceeded The thermometer was not use. censed practical nurse (LPN)-B netering the facility wearing a ad eye protection, was observed f COVID-19 symptom screening wn temperature using the hermometer, and entered her the screening form. The s not disinfected after use. At no continuous observation of the ss staff was the thermometer 38 a.m., NA-E was observed to OVID-19 symptom screening de the building wearing no mask on. No screener was t the COVID-19 symptom n; NA-E took her own filled out the COVID-19 NA-D came to the screening and NA-E then proceeded to NA-E was able to enter the her entrance without a screening through the facility to the n without a mask or appropriate	FOOU	to screening down. 9/16/20, at 8:45 a.m. S1 and S2 walka into the facility and their temperatures were taken by a staff member. S1 and signed into the facility and wrote their temperatures down. No further information was gathered by facility st S1 and S2 proceeded to the elevator went to the 3rd floor. 9/17/20, at 8:15 a.m. S2 walked into t facility. There was a table with different forms, masks, and a thermometer. S2 waited by the table for a staff member greet her. A staff member (from housekeeping) walked over and told S sign in. Kebeh Zaimah, CNA-4 came screen S2. Kebeh Zaimah, CNA-4 came screen S2. Kebeh Zaimah, CNA-4 too S2s temperature and had S2 sign her name on the "Visitor Sign In" form. 9/17/20, at 8:18 a.m. Marissa Hoffma Social Worker and Julia Vera, Staff Member-1 came in through the front of Social Worker and Staff member-1 to their own temperatures and wrote dow information on the Daily Staff Screeni Log in response to symptoms related COVID-19 without anyone verbally as them. 9/17/20, at 8:38 a.m. Angeline, Staff Member-2 came from inside the build to the screening area with no mask an sunglasses on. Staff member-2 walket to the table where staff and visitors ar be screened by the main door. There no one at the table when Angeline, Staff	d S2 aff. and he nt 2 r to S2 to bk n, door. ok wn ng to king ing nd ed up e to was aff		
	stated she entered performed hand	ed on 9/17/20, at 8:40 a.m., NA-E ed the facility near the kitchen, hygiene, then walked through the across the hall to the main lobby		No one at the table when Angeline, St Member-2 approached. Angeline, Sta Member-2 took her own temperature filled out questions related to COVID-	ff and		

Facility ID: 00176

If continuation sheet Page 5 of 10

	OF DEFICIENCIES	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		D. 0938-039 TE SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	Co	MPLETED	
		24E185	B. WING	0	09/18/20 <u>20</u>	
NAME OF F	ROVIDER OR SUPPLIE	R	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BYWOOI	EAST HEALTH C	ARE		427 CENTRAL AVENUE NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 5	F 880			
	for COVID-19 syn stated most staff NA-E also stated by the kitchen do employee parking door have to wall screened. On 9/17/20, at 10 was observed sta no face mask or interviewed on 9/ stated he did not protection in the up and the mask further stated he eye protection in On 9/17/20, at 10 enter the kitchen wearing a face m When interviewe trained medication entered the facilit the back door. The their own temper filled out the staff stated the nurse available, otherw	<ul> <li>mptom screening. NA-E further enter through the kitchen door. there was no screening station or, which was closest to the g lot; staff that walk in the kitchen k through the facility to get</li> <li>2:15 a.m., dietary aide (DA)-A anding near the dishwasher with eye protection in place. When 17/20, at 10:15 a.m., DA-A wear a face mask or eye dish room as the goggles fogged made it hard to breath. DA-A would wear a face mask and other areas of the facility.</li> <li>2:18 a.m. DA-B was observed to from the resident serving line hask positioned below chin level.</li> <li>d on 9/18/20, at 10:55 a.m., on aid (TMA)-C stated staff ty either through the front door or WA-C further stated staff took ature, sanitized their hands, and f screening sheet. TMA-C further filled out the screening form if ise staff do it themselves. ated the thermometer was</li> </ul>		without anyone asking. Kebah Zaimah, CNA-4 approached the table were Staff Member-2 was. During an interview with Angeline Johnson, Staff member-2 on 9/17/20, at 8:40 a.m. Staff Member-2 reported to have come into the facility through a door by the kitchen. Angeline, Staff member-2 said she would put sanitizer on each time entered, walk through the dining room through the hall to the front main lobby to get screened. Angeline, Staff Member-2 reported to always come in through the door by the kitchen and so do most other staff. 9/17/20, at 9:42 a.m. Administrator approached S1 and S2 to discuss the dietary department and not wearing appropriate PPE on 9/16/20. Administrator explained her recent conversation with the dietary department about her observations of dietary staff nor wearing appropriate personal protective equipment (PPE). Administrator stated she followed up with the FSD about her observation and FSD provided education to her staff. Administrator said later that day she caught the FSD not wearing eye protection or a mask after she had just educated on the need. Administrator wen over the need for appropriate PPE and	t	
	sanitizer. When interviewe infection preventi expectation that a	o or three uses with hand d on 9/18/20, at 2:13 p.m., the ionist (IP) stated it would be her a nurse or other staff would be caff COVID-19 symptom		reeducated the FSD and dietary staff. The FSD was sent home for not wearing appropriate PPE and corrective action was provided to staff. 9/17/20, at 10:15 a.m. Glenn rock, Dietar aide-1 was observed through a window to	y	

Facility ID: 00176

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	OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI	E CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		24E185	B. WING	ETN	0.0/	18/2020
	PROVIDER OR SUPPLI		s	TREET ADDRESS, CITY, STATE, ZIP COD		10/2020
	$\sim$			427 CENTRAL AVENUE NORTHEAST		
BYWOO	D EAST HEALTH C	ARE	N	MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 880	Continued From	page 6	F 880			
		IP further stated staff should all		standing near the dishwasher	with no	
		cal masks and eye protection		eyewear or no face mask on. I		
	while in the facili			Aide-1 stated understanding o		
		-5-		to wear goggles and a mask b		
	When interviewe	d on 9/18/20, at 3:17 p.m., the		the dish room as the goggles f		
	DON stated it wo	ould be her expectation that staff		Dietary Aide-1 said the mask r		
	fill out the COVI	D-19 symptom screening form		stuffy and hard to breath. Whe	n not in the	
	and take their ov	vn temperature, but the		dish room, Dietary Aide-1 said	a face	
		ld be verified by another staff		covering and goggles are worr		
	member. The DO	ON further stated the staff				
		ometer should be disinfected		9/17/20, at 10:18 a.m. Yougal		
		he DON further stated it was her		Cook-1 was near baked chicke		
		staff follow the required PPE of		mask on, eyes not covered bu		
		fied the current requirement was		goggles on his forehead. Cook		
		a surgical mask and eye		buttering chicken. Dietary Aide		
	protection while	in the building.		through the kitchen with no ma protection. Sherry Y, Dietary A		
		sident Admissions and Care		in from the tray line area with a	a mask	
		c - COVID 19, revised 8/20,		below her chin.		
		f were to be actively screened for				
		orting to work, and all staff were		The Interim Infection Preventi		
		r a procedure mask and		Control Recommendations for		
		ear at all times when in the		Personnel During Coronavirus		
		icy further indicated all continue to actively follow		2019 (COVID-19) Pandemic d 15, 2020 by the Center for Dis		
		IDH, CDC, CMS and other		Control /6/2020, indicated hea		
	appropriate guid			facilities should actively take te		
	Spp. Spriato guid			and document symptoms cons		
	The Center for D	Disease Control Interim Infection		COVID-19 and to implement u		
		Control Recommendations for		source control measure which		
	Healthcare Pers	onnel During Coronavirus		health care personal (HCP) sh	ould wear a	
	Disease 2019 (C	OVID-19) Pandemic dated July		facemask at all times while the		
		ed health care facilities should		facility and HCP working in fac		
		peratures and document		located in areas with moderate		
		stent with COVID-19 and to		substantial community transm		
		rsal source control measures		should wear eye protection in a	addition to	
		ealth care personal (HCP)		their facemask.		
		cemask at all times while they			4h a	
	are in the facility	and HCP working in facilities		No residents were affected by	uie	

Facility ID: 00176

If continuation sheet Page 7 of 10

	-	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 10/27/202 FORM APPROVE OMB NO. 0938-039	
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E185	B. WING _		09/18/2020	
	PROVIDER OR SUPPLI D EAST HEALTH C			STREET ADDRESS, CITY, STATE, ZIP COD 3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418	ORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLÉTIC	
F 880	located in areas community trans	page 7 with moderate to substantial mission should wear eye lition to their facemask.	F 8	<ul> <li>deficient practice. No resident been diagnosed with COVID s date of this survey. All resider potential to be affected by the practice.</li> <li>We continue to assess resider signs and symptoms twice dai potential COVID symptoms. F there are none.</li> <li>Some members of the facilitie: Assurance and Performance Improvement Committee met i root cause analysis (RCA) to id problem(s) that resulted in this and develop intervention or co action plan to prevent recurrer 10/9/2020.</li> <li>The Director of Nursing and In Preventionist met to review, de implement procedures, policie forms regarding active screenit temperature and signs and syn COVID-19, in accordance with guidelines to be conducted at the entry for every person who entifacility. The procedures and por restrict entrance to anyone wh meet the criteria as outlined by This procedure must include a measuring and recording staff temperature and assessment of breath, new or changed cous sore throat. The results must documented. The new form to this screening was implemented of 26/20. All staff are screened forms regarding was implemented forms to this screening was implemented forms to the screening was implemented forms to this screening was implemented forms to the screening</li></ul>	ince the its have a deficient hts vital ly to identify Presently s Quality to conduct a dentify the a deficiency rrective nce on fection evelop and s, and ing for mptoms of o CDC the point of ters the blicy must o does not y the CDC. ictively of shortness igh, and be o document ed on	

Facility ID: 00176

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	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION (X3) D/	D. 0938-039 ATE SURVEY OMPLETED		
		24E185	B. WING		09/18/2020		
NAME OF I	PROVIDER OR SUPPLIE		S <sup>_</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE			
BYWOO	D EAST HEALTH C	ADE	34	427 CENTRAL AVENUE NORTHEAST			
ы	DEAST HEALTH C	ARE	м	IINNEAPOLIS, MN 55418			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 8	F 880				
				entering the building at the beginning of their shift including having their temperature taken and questions asked about other signs and symptoms of COVID-19 as identified by the CDC. This is documented on a standard form. Surgical masks and protective eyewear are available to be picked up at this time during screening.	5		
				The DON and Infection Preventionist reviewed policies and procedures for donning/doffing PPE for TBD and during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care and to develop and implement a policy and procedure for source control masks and reviewed policies regarding standard and transmission based precautions and revised as needed on 10/9/2020.			
				The Infection Preventionist completed the certification program recommended by CMS on 9/28/19.	Э		
				Training will be presented to all staff on proper masking and donning and doffing personal protective equipment and disinfection on 10/16/2020.			
				Audits are being conducted 5x a week by management staff as designated by the Director of Nursing. The DON audits evenings, nights, and weekends through the facility surveillance system.	,		

TATEMENT	OF DEFICIENCIES F CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION (X3)	NO. 0938-039 DATE SURVEY COMPLETED	
		24E185	B. WING		09/18/20 <u>20</u>	
	PROVIDER OR SUPPLIE		34	TREET ADDRESS, CITY, STATE, ZIP CODE 427 CENTRAL AVENUE NORTHEAST IINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 9	F 880	the plan at a meeting 10/16/2020.		
				The results of audits and monitoring wi be reviewed at the next QAPI meeting October 16, 2020.	II	

Facility ID: 00176

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			•		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E185	B. WING			C 09/18/2020	
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                     </u>	
BYWOOI	D EAST HEALTH CAR	96		34	427 CENTRAL AVENUE NORTHEAST		
BIWOOI				M	IINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	was conducted 9/18 by the Minnesota D determine compliar Preparedness regu facility was IN full co Because you are er signature is not req page of the CMS-29 Although no plan of required that the fac the electronic docu INITIAL COMMENT A COVID-19 Focus was conducted 9/18 by the Minnesota D determine compliar	nrolled in ePOC, your uired at the bottom of the first 567 form. correction is required, it is cility acknowledge receipt of ments.	FO	00			
	as your allegation o Department's accep						
		nrolled in ePOC, your uired at the bottom of the first 567 form.					
	revisit of your facilit	acceptable electronic POC, a y will be conducted to validate nce with the regulations has cordance with your					
		rd survey was completed at					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						10/09/2020

**Electronically Signed** 

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.

PRINTED: 11/02/2020

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		24E185	B. WING	B. WING			) 18/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BYWOOI	D EAST HEALTH CAR	RE			427 CENTRAL AVENUE NORTHEAST IINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 089 SS=J	Health to determine compliance with red 483, Subpart B, and Care Facilities. The survey resulted to resident health a on 9/10/20, when th sound in response facility. The facility wanderguard system enhanced supervisid did elope from the f director of nursing ( for R1 on 9/17/20, a immediately implen 9/11/20, and F689 i non-compliance. In addition, an exter 9/18/20, related to the findings. Complaint HE18509 for past non-compli- had implemented c survey, harm or imm sustained prior to the Although no plan of finding of past non- facility acknowledge documents. Free of Accident Hat	Minnesota Department of e if your facility was in quirements of 42 CFR Part d Requirements for Long Term d in an immediate jeopardy (IJ) nd safety. An IJ at F689 began ne wanderguard alarm did not to a resident (R1) exiting the failed to ensure the m was operational or provide ion of R1. Subsequently, R1 facility. The administrator and (DON) were notified of the IJ at 11:37 a.m. The facility nented correction action on s being issued at past nded survey was completed the substandard quality of care 93 was unsubstantiated, and 92 was substantiated at F689, ance. Although the provider orrective action prior to mediate jeopardy was he correction.	F C	689	DEFICIENCY)		10/8/20

If continuation sheet Page 2 of 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG_			C		
		24E185	B. WING			09/18/2020			
NAME OF F	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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DN SHOULD BE COMPLETI IE APPROPRIATE DATE			
F 689	as free of accident I §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility fa wanderguard was fi elopment for 1 of 3 elopements. This re jeopardy (IJ) when I on 9/10/20 and was was found by police immediately implem corrected the deficit issued as past none Jeopardy (IJ). The IJ that began o 9/11/20 when the fa interventions to pre- administrator and d notified of the IJ pas at 11:37 a.m., as a corrective action tal Findings include: R1's admission Min 7/2/20, indicated R1 dementia, bipolar, o pulmonary disorder cognitive impairmer	ts. sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced ion, interview and document ailed to ensure the unctioning to prevent an residents (R1) reviewed for esulted in an immediate R1 eloped out of the building missing for 3.5 hours and e unharmed. The facility nented interventions and ent practice on 9/11/20. This is complaince at Immediate n 9/10/20 was corrected on cilty implemented vent reoccurance. The irector of nursing (DON) were st noncomplaince on 9/17/20, result of the immediate	F 6	89	Past noncompliance: no plan of correction required.				

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PRINTED: 11/02/2020

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	(X2) MUI	тір	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			G		IPLETED
						,	С
		24E185	B. WING				- 18/2020
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
DVMOOL				;	3427 CENTRAL AVENUE NORTHEAST		
BYWOOD EAST HEALTH CARE			ľ	MINNEAPOLIS, MN 55418			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
TAG			IAG		DEFICIENCY)		
1							
F 689	Continued From pa	ige 3	F 6	386	9		
	to surface transfers	•					
		r Mental Status (BIMS) was					
		pleted on 8/21/20, that					
	indicated R1 had se	evere cognitive impairment.					
	A wandar rick acco	ssment completed on 8/19/20,					
		ted behaviors of refusals,					
		it, impulsive behavior, and had					
		y within the facility or grounds					
		th. The assessment further					
		eemed unsafe to leave the					
	facility unescorted.						
	R1's care plan, last	reviewed 8/18/20, indicated					
		isk, had a wanderguard alarm					
	in place, and was d	leemed unsafe to leave the					
	facility unescorted.						
	A progress note dat	ted 9/10/20, at 9:11 a.m.					
		ersistently asking for					
		Id not wait for staff, setting off					
	the door alarm. The	e progress note further					
		bund walking down the alley,					
	just off campus, and	d was redirected.					
	A progress note dat	ted 9/10/20, at 1:23 p.m.					
		the living room door with a					
		nd the alarm did not sound.					
		ted 9/10/20, at 1:41 p.m.					
		enance director (MD)-A was					
	R1 to see if it was d	check the wanderguard on					
		Jelecuve.					
	An email from the f	ood services director (FSD)-B					
		10/20, at 1:44 p.m., had a					
	subject that indicate	ed to please check, and further					
	indicated R1 went of	out the living room door and					

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PRINTED: 11/02/2020
		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		24E185	B. WING			C 09/18/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BYWOOI	D EAST HEALTH CAR	ξE		-	427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From particle alarm did not so A progress note dat R1 had not been se around the facility s was provided by pro- the facility. Staff sea vicinity but were un- administrator, case notified. A progress note dat indicated R1 was b 10:30 p.m. and R1 When interviewed of FSD-B stated R1 ez door, and the alarm stated she charted MD-A, asking him t further stated she d will copy the admini- future. FSD-B confi- disciplinary action a elopement procedu When interviewed of MD-A stated when a working he should B call, "anything but a with an urgent issue resort. When interviewed of facility administrato the email notificatio	ige 4 bund. ted 9/10/20, at 8:34 p.m. noted een by any staff member in or since 3:00 p.m. and no report evious shift about R1 leaving arched for R1 around the able to find R1. The DON, manager, and police were ted 9/10/20, at 10:53 p.m., rought back by police at about was noted to have no injuries. on 9/16/20, at 12:09 p.m., xited through the living room a didn't sound. FSD-B further the incident and emailed o check the door. FSD-B lid not notify anyone else, but istrator or the DON in the rmed having received and re-education regarding	1	589	DEFICIENCY)		
	The administrator f	urther stated FSD-B did not the alarm was not working					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		24E185	B. WING				C 18/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BYWOOI	D EAST HEALTH CAR	E			427 CENTRAL AVENUE NORTHEAST /IINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	Continued From pa properly. The admir 9/11/20, at approxim MD-A reported the w had already been of working properly. When interviewed of MD-A stated there w of the wanderguard MD-A further stated the key pads and un that the magnet is of lights indicate the d On 9/16/20, at 12:0 nurse (LPN)-A was the smoking patio in and R1 passed thro sounded appropriat When interviewed of stated a staff memb smoke. R1 further st facility. When interviewed of trained medication a residents' wandergue each shift and the e night to make sure When interviewed of nursing assistant (N received training of	ge 5 histrator contacted MD-A on nately 6:00 a.m., at which time wanderguard alarm system hecked that morning and was on 9/16/20, at 11:45 a.m., were no issues during an audit alarm system on 9/11/20. I during an audit he ensures nit power sensor works and on. MD-A further stated green oor unit was in working order. 7 p.m., licensed practical observed to escort R1 from hto the facility. When LPN-A bugh the door, the alarm	1	589	DEFICIENCY)		
	resident before dea	alarm and must locate the ctivating the alarm. on 9/16/20, at 10:07 a.m.,					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		24E185	B. WING				C 18/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BYWOO	D EAST HEALTH CAR	₹E			427 CENTRAL AVENUE NORTHEAST IINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	NA-B stated all staf regarding elopemen residents were at ri When interviewed of NA-C stated she re how to respond if si elopes from the fac charge nurse would resident could not b When interviewed of housekeeping staff education on elope he first started work year, and had recen related to elopemen wanderguard alarm When interviewed of LPN-A stated R1 ha cognitively impaired appropriate interven and worked well for When interviewed of DON stated the fac placement on resid wanderguard functi residents with wand stated if it were not was not working the DON, infection prev assistant administra further stated staff have increased mo was an issue with a DON also stated, in	ff were recently re-educated nt procedures, including which sk and how to respond. on 9/16/20, at 12:21 p.m., ecently received education on omeone with a wanderguard cility. NA-C further stated the d be immediately informed if a be located. on 9/16/20, at 12:26 p.m., f (H)-A stated he received ment and wanderguards when king at the facility earlier in the ntly read new education nt and how to respond to the	F 6	89			

Facility ID: 00176

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		24E185	B. WING	i			C 18/2020
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BYWOO	D EAST HEALTH CAR	₹E			427 CENTRAL AVENUE NORTHEAST /IINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	wanderguard alarm and staff did not rea another resident se The DON added wh missing they search grounds, called the incident to the State DON stated all staff elopement policy. When interviewed of administrator state the administrator at wanderguard alarm versus writing an en The policy titled Wa Prevention Plan Po 6/20, indicated it wa provide a safe envit policy further indicate be assessed as new wandering preventi staff would inform r maintenance or new The document titled Refresher, dated 9/ residents with a wa when the wandergu should check for re outside the building protocol refresher f not turn off the wan are 100% certain re are safe and accourt	a went off around 3:30 p.m., alize R1 had eloped when et off the wanderguard alarm. hen the facility realized R1 was hed rooms, the building police and reported the e Agency (SA). Finally, the f had been re-educated on the on 9/17/20, at 9:39 a.m., the d FSD-B should have notified nd DON immediately about the n not sounding on 9/10/20, mail to MD-A. andering / Elopement blicy and Procedure, updated as the policy of the facility to ronment for all residents. The ated the safety care plan would eded to ascertain appropriate on. The policy further indicated maintenance of any alarm eded repair work. d Wanderguard Protocol /11/20, included images of inderguard, and indicated uard alarm sounds, staff esidents on a wanderguard g and around corners. The further indicated staff should inderguard alarm unless they esidents with a wanderguard		589			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24E185	B. WING	i		C 09/18/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BYWOOI	D EAST HEALTH CAR	E			427 CENTRAL AVENUE NORTHEAST IINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689 F 880 SS=F	facility took the follo and correct the defi audit of the wander wanderguard brace ensure they were in 9/11/20, disciplinary regarding equipmer maintenance staff a wanderguard malfu elopement protocol will check the grour residents with a wan door alarm. All staff facility elopement p on 9/11/20. Verificat confirmed by intervi and non-nursing sta provided and staff v administrative staff the wanderguard sy notification is receiv Infection Preventior CFR(s): 483.80(a)(1) §483.80 Infection C The facility must es infector prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infectior program. The facility must es	wing steps to remove the IJ cient practice: On 9/11/20, an guard system, including all lets used, was completed to a proper working order. On y action and re-education in malfunction was provided to and staff that observed the nction. On 9/11/20, the was updated to indicate staff inds thoroughly and account for inderguard in response to the f were re-educated to the olicy and protocol beginning tion of corrective action was iew with a variety of nursing aff that verified education was will notify maintenance and of any possible malfunction of ystem and ensure the yed. n & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ions. n prevention and control tablish an infection prevention in (IPCP) that must include, at		589 380			10/9/20

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		24E185	B. WING	i			C 18/2020
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BYWOOI	D EAST HEALTH CAR	٤E.			3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited to (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pre (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement th least restrictive pos circumstances. (v) The circumstance must prohibit employ disease or infected contact with resider contact with resider by staff involved in or contact with resider	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ing to §483.70(e) and following standards; en standards, policies, and program, which must include, to: eillance designed to identify table diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the table for the resident under the ces under which the facility byees with a communicable skin lesions from direct ints or their food, if direct	Fξ	380			
	3.00.00(0)(+)/(0)0		I				

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	( <b>V</b> 2) MU	тірі	E CONSTRUCTION		SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
			A. DOILD	- <sup>1</sup>			~
		24E185	B. WING				, 18/2020
NAME OF F				S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2020
					427 CENTRAL AVENUE NORTHEAST		
BYWOOI	D EAST HEALTH CAR	E			IINNEAPOLIS, MN 55418		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX			PREFIX	х	(EACH CORRECTIVE ACTION SHOULD		COMPLÉTION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IAIE	DATE
			1				
F 880	Continued From no	ao 10	го	00			
1 000	Continued From pa	-	F 8	80			
		facility's IPCP and the					
	corrective actions ta	aken by the facility.					
	§483.80(e) Linens.						
		ndle, store, process, and					
		as to prevent the spread of					
	infection.						
	§483.80(f) Annual r						
		duct an annual review of its					
		eir program, as necessary.					
		NT is not met as evidenced					
	by:	ion interview and decomposit			Deced on charmination interview or	- d	
		ion, interview and document a			Based on observation, interview ar document review, the facility failed		
		ection control program to			implement a comprehensive infecti		
		led COVID-19 staff health			control program to include recomm		
		es, disinfection of shared			COVID-19 staff health screening lo		
		aring of appropriate personal			procedures and wear appropriate	oution	
		nt (PPE). This had the			personal protective equipment. This	is had	
		Il 77 residents in the facility			the potential to affect all 77 residen		
					resided in the facility		
	Findings include:						
	Duminan a stiller				Findings include:		
	-	observations on 9/17/20, from			0/15/20 at 12:45 pm Summer 4	and	
		a.m., the following was noted:			9/15/20, at 12:45 p.m. Surveyor- 1 Surveyor 2 walked into the facility.		
		nidentified staff member was he facility; no staff were			Surveyor 2 walked into the facility. S2 signed their names on a form w		
		ID-19 symptom screening			they entered the facility. A staff mer		
		tified staff member took his			took temperatures of S1 and S2. S		
		vice, filled out a symptom			asked staff member if they had any		
		d proceded to enter the			questions. The staff member aske		
	-	no screener to ensure the			screening questions related for CO		
		ember did not enter the faciltiy			but did not write the answers provid	led by	
		ns. The thermometer was not			S1 and S2 down on their tracking lo		
	sanitized after use.				asked the staff member if they were		
		8:16 a.m., nursing assistant			to write down S1 and S2 COVID 19		
		e screening desk from			screening questions. The staff men		
	another area within	the facility, and was observed			proceeded and wrote S1 and S2 ar	iswers	

Facility ID: 00176

PRINTED: 11/02/2020

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION (X:	COMF	SURVEY
		24E185	B. WING	WING		C 09/18/2020	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BYWOO	D EAST HEALTH CAR	RE			3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIC DATE
F 880	at screening desk when social worker (SW)-A			880	to screening down.	a d	
	out the COVID-19 s on the staff screeni temperature with th thermometer, saniti into the building. Th disinfected after us At 8:19 a.m., licer was observed enter	ntered the building. SW-A donned a mask, filled at the COVID-19 symptom screening questions in the staff screening form, took her own mperature with the non-disinfected ermometer, sanitized her hands and proceeded to the building. The thermometer was not sinfected after use. At 8:19 a.m., licensed practical nurse (LPN)-B as observed entering the facility wearing a			9/16/20, at 8:45 a.m. S1 and S2 walke into the facility and their temperatures were taken by a staff member. S1 and signed into the facility and wrote their temperatures down. No further information was gathered by facility st S1 and S2 proceeded to the elevator went to the 3rd floor.	s d S2 taff. and	
	to fill out the staff C form, took her own non-disinfected the temperature on the thermometer was n time during the con	eye protection, was observed OVID-19 symptom screening temperature using the rmometer, and entered her screening form. The not disinfected after use. At no tinuous observation of the staff was the thermometer			9/17/20, at 8:15 a.m. S2 walked into the facility. There was a table with different forms, masks, and a thermometer. S2 waited by the table for a staff member greet her. A staff member (from housekeeping) walked over and told S sign in. Kebeh Zaimah, CNA-4 came screen S2. Kebeh Zaimah, CNA-4 too S2s temperature and had S2 sign her name on the "Visitor Sign In" form.	with different nometer. S2 aff member to (from er and told S2 to NA-4 came to , CNA-4 took S2 sign her In" form. asa Hoffman, era, Staff n the front door. ember-1 took d wrote down aff Screening ms related to verbally asking eline, Staff de the building	
	approach the COVI station from inside sunglasses and no initially present at the screening station; No temperature and fill screening form; No table at this time are enter the facility. No facility from another station and walk the	led out the COVID-19 -D came to the screening nd NA-E then proceeded to A-E was able to enter the r entrance without a screening rough the facility to the			<ul> <li>9/17/20, at 8:18 a.m. Marissa Hoffman Social Worker and Julia Vera, Staff Member-1 came in through the front of Social Worker and Staff member-1 to their own temperatures and wrote dow information on the Daily Staff Screenin Log in response to symptoms related COVID-19 without anyone verbally as them.</li> <li>9/17/20, at 8:38 a.m. Angeline, Staff Member-2 came from inside the build to the screening area with no mask ar</li> </ul>		
	eye protection. When interviewed of stated she entered performed hand hyperformed hyperformed hyperformed hand hyperformed hand hyperformed hand hyperformed hand hyperformed	ithout a mask or appropriate on 9/17/20, at 8:40 a.m., NA-E the facility near the kitchen, giene, then walked through the ross the hall to the main lobby			sunglasses on. Staff member-2 walke to the table where staff and visitors ar be screened by the main door. There no one at the table when Angeline, Sta Member-2 approached. Angeline, Sta Member-2 took her own temperature filled out questions related to COVID-	re to was taff aff and	

Facility ID: 00176

	CS FOR MEDICARE	& MEDICAID SERVICES	(Y2) MU	יסוד			0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
			A. BOILDI			C	2
		24E185	B. WING				8/2020
NAME OF I	PROVIDER OR SUPPLIER	•	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BYWOO	D EAST HEALTH CAR	RE			427 CENTRAL AVENUE NORTHEAST /INNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 880	Continued From pa	ige 12	F 8	80			
	for COVID-19 symp stated most staff er NA-E also stated th by the kitchen door employee parking le door have to walk th screened. On 9/17/20, at 10:1 was observed stand no face mask or ey interviewed on 9/17 stated he did not we protection in the dis up and the mask m further stated he we eye protection in ot On 9/17/20, at 10:1 enter the kitchen fro wearing a face mas When interviewed of trained medication entered the facility the back door. TMA their own temperatu filled out the staff so stated the nurse fille available, otherwise TMA-C further state cleaned every two of sanitizer. When interviewed of infection prevention	<ul> <li>botom screening. NA-E further there through the kitchen door. here was no screening station , which was closest to the ot; staff that walk in the kitchen hrough the facility to get</li> <li>5 a.m., dietary aide (DA)-A ding near the dishwasher with e protection in place. When 7/20, at 10:15 a.m., DA-A ear a face mask or eye sh room as the goggles fogged ade it hard to breath. DA-A ould wear a face mask and her areas of the facility.</li> <li>8 a.m. DA-B was observed to om the resident serving line sk positioned below chin level.</li> <li>bon 9/18/20, at 10:55 a.m., aid (TMA)-C stated staff either through the front door or A-C further stated staff took ure, sanitized their hands, and creening sheet. TMA-C further ed out the screening form if e staff do it themselves. ed the thermometer was or three uses with hand</li> <li>bon 9/18/20, at 2:13 p.m., the hist (IP) stated it would be her</li> </ul>			without anyone asking. Kebah Zaima CNA-4 approached the table were Sta Member-2 was. During an interview with Angeline Johnson, Staff member-2 on 9/17/20, 8:40 a.m. Staff Member-2 reported to have come into the facility through a by the kitchen. Angeline, Staff member said she would put sanitizer on each entered, walk through the dining room through the hall to the front main lobb get screened. Angeline, Staff Member reported to always come in through the door by the kitchen and so do most of staff. 9/17/20, at 9:42 a.m. Administrator approached S1 and S2 to discuss the dietary department and not wearing appropriate PPE on 9/16/20. Administrator explained her recent conversation with the dietary departm about her observations of dietary staff wearing appropriate personal protectif equipment (PPE). Administrator states she followed up with the FSD about he observation and FSD provided educat to her staff. Administrator said later th day she caught the FSD not wearing protection or a mask after she had just educated on the need. Administrator over the need for appropriate PPE and reeducated the FSD and dietary staff FSD was sent home for not wearing appropriate PPE and corrective action was provided to staff.	taff b, at c door ber-2 time m by to ber-2 he other e nent ff not tive ed her ation hat eye sst went nd f. The on	
	infection prevention expectation that a r present for the staft					ietary	

					DMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
					(	2
		24E185	B. WING	NG		18/2020
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
BYWOO	D EAST HEALTH CAP	RE		3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 880	Continued From pa	age 13	F 880			
	themselves. The IF be wearing surgica while in the facility. When interviewed of DON stated it woul fill out the COVID-1 and take their own information should member. The DON screening thermom between uses. The expectation that sta the day, and verifie for staff to wear a s protection while in the A policy titled Resid During Pandemic - indicated all staff w illness upon reporti expected to wear a protective eyewear building. The policy	P further stated staff should all I masks and eye protection on 9/18/20, at 3:17 p.m., the d be her expectation that staff 19 symptom screening form temperature, but the be verified by another staff I further stated the staff neter should be disinfected DON further stated it was her aff follow the required PPE of d the current requirement was surgical mask and eye the building. dent Admissions and Care COVID 19, revised 8/20, rere to be actively screened for ng to work, and all staff were procedure mask and at all times when in the		<ul> <li>standing near the dishwasher with eyewear or no face mask on. Dief Aide-1 stated understanding of the to wear goggles and a mask but of the dish room as the goggles fog Dietary Aide-1 said the mask mak stuffy and hard to breath. When n dish room, Dietary Aide-1 said a facovering and goggles are worn.</li> <li>9/17/20, at 10:18 a.m. Yougal Tse Cook-1 was near baked chicken with a goggles on his forehead. Cook-1 buttering chicken. Dietary Aide-1 states protection. Sherry Y, Dietary Aide-1 with no mask protection. Sherry Y, Dietary Aide-1 with a mask on the tray line area with a mask onter the tray line area</li></ul>	ary e need loesn't in up. es it ot in the ace ten, with a ad was walked or eye -2 came ask and althcare sease d Julye	
	governmental, MDI appropriate guidelin The Center for Dise Prevention and Con Healthcare Person Disease 2019 (COV 15, 2020, indicated actively take temper symptoms consister implement universa which included heal should wear a face	H, CDC, CMS and other		Control /6/2020, indicated health of facilities should actively take temp and document symptoms consiste COVID-19 and to implement univer- source control measure which inco- health care personal (HCP) shoul facemask at all times while they a facility and HCP working in facilitie located in areas with moderate to substantial community transmissi should wear eye protection in add their facemask.	care beratures ent with ersal ludes d wear a re in the es on ition to	

Facility ID: 00176

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TATEMEN	OF DEFICIENCIES OF CORRECTION	A MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. (X3) DATE COMF	
		24E185	B. WING			; 8/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (		0.2020
BYWOO	D EAST HEALTH CA	RE		3427 CENTRAL AVENUE NORTHEA MINNEAPOLIS, MN 55418	AST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 880	community transm	age 14 ith moderate to substantial ission should wear eye on to their facemask.	F 8	<ul> <li>80</li> <li>deficient practice. No resid been diagnosed with COVII date of this survey. All resi- potential to be affected by t practice.</li> <li>We continue to assess resi- signs and symptoms twice potential COVID symptoms there are none.</li> <li>Some members of the facil Assurance and Performand Improvement Committee m root cause analysis (RCA) to problem(s) that resulted in and develop intervention or action plan to prevent recur 10/9/2020.</li> <li>The Director of Nursing and Preventionist met to review implement procedures, poli forms regarding active screet temperature and signs and COVID-19, in accordance w guidelines to be conducted entry for every person who facility. The procedures and restrict entrance to anyone meet the criteria as outlined This procedure must includ measuring and recording st temperature and assessme of breath, new or changed sore throat. The results mu documented. The new forr this screening was impleme 6/26/20. All staff are screet</li> </ul>	D since the dents have a he deficient dents vital daily to identify a Presently ities Quality be to conduct a to identify the this deficiency corrective rence on d Infection develop and cies, and beining for symptoms of with CDC at the point of enters the d policy must who does not d by the CDC. e actively taff ent of shortness cough, and ust be n to document ented on	

Facility ID: 00176

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING B. WING B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3427 CENTRAL AVENUE NORTHEAST	(X3) DATE SURVE COMPLETED C 09/18/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  3427 CENTRAL AVENUE NORTHEAST	09/18/2020	0
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BYWOOD EAST HEALTH CARE MINNEAPOLIS, MN 55418	۱ (X5	
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F 880       Continued From page 15       F 880         entering the building at the beginnin their shift including having their temperature taken and questions as about other signs and symptoms of COVID-19 as identified by the CDC. is documented on a standard form. Surgical masks and protective eyew are available to be picked up at this during screening.         The DON and Infection Preventionis reviewed policies and procedures for donning/doffing PPE for TBD and di COVID-19 with current guidelines to include crisis standard of care e, contingency standard of care e, contingency standard of care and to develop and standard care and to neviewed policies regarding standard and transmission based precautions and reviseed as needed on 109/2020.         The Infection Preventionis complete certification program recommended CMS on 9/28/19.         Training will be presented to all staff proper masking and donning and do personal protective equipment and disinfection on 10/16/2020.         Audits are being conducted 5x a we management staff as designated by Director of Nursing. The DN and the synthese system.	sked sked This vear time st or uring o for d ted the d by f on offing eek by y the ts rough	

Event ID: JQ6X11

Facility ID: 00176

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM A							APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE	IB NO. 0938-0391           (X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			PLETED	
		24E185	B. WING			C 09/18/2020		
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BIWOOL		• <b>C</b>	MINNEAPOLIS, MN 55418					
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F 880	Continued From pa	ae 16	F 88	80				
	Continued From pu		1 00	50	the plan at a meeting 10/16/2020.			
					The results of audits and monitoring will be reviewed at the next QAPI meeting October 16, 2020.			

Facility ID: 00176

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PRINTED: 11/02/2020



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 8, 2020

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

Re: Event ID: JQ6X11

Dear Administrator:

The above facility survey was completed on September 18, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kumalu 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: <u>kamala.fiske-downing@state.mn.us</u>

PRINTED: 10/21/2020 FORM APPROVED

Minneso	ota Department of H	ealth				/ / / / / / / / / / / / / / / / / / / /
STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		, <i>,</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		00176	IN U J 7		09/1	8/2020
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2 000	Initial Comments		2 000			
	****ATTE	ENTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surv found that the defi herein are not corr not corrected shall with a schedule of the Minnesota Dep Determination of v corrected requires requirements of th number and MN R When a rule conta comply with any of lack of compliance re-inspection with result in the asses	n Minnesota Statute, section ection order has been issued ey. If, upon reinspection, it is ciency or deficiencies cited rected, a fine for each violation be assessed in accordance fines promulgated by rule of partment of Health. Whether a violation has been compliance with all e rule provided at the tag fule number indicated below. ins several items, failure to the items will be considered e. Lack of compliance upon any item of multi-part rule will sment of a fine even if the iter luring the initial inspection wa	s on II em			
	that may result fro orders provided th the Department wi	a hearing on any assessment m non-compliance with these at a written request is made thin 15 days of receipt of a ent for non-compliance.	e			
	was conducted to State Licensure. Y	TS: 8/20, an abbreviated survey determine compliance with our facility was found to be IN ne MN State Licensure.	N			
	UNSUBSTANTIAT	plaint was found to be ED: HE185093. NO licensing	g			
LABORATOR	epartment of Health Y DIRECTOR'S OR PROV ically Signed	DER/SUPPLIER REPRESENTATIVE'S	SIGNATURE	TITLE		(X6) DATE 10/09/20

If continuation sheet 1 of 2

PRINTED: 10/21/2020 FORM APPROVED

NUMERATION ENTRY         (N) INCREMENDING         (OC) MULTINE CONSTRUCTION         (OC) DATE SURVEY           NUMPLY NO PROVIDER ON SUPPLY         CONTR         CONTR         CONTR           NUME OF PROVIDER ON SUPPLY         STREET ADDRESS (TV, STATE_ZIP CODE         CONTR         CONTR           YWOO TAST HEALTH CARE         STREET ADDRESS (TV, STATE_ZIP CODE         CONTR         CONTR         CONTR           YWOO TAST HEALTH CARE         STREET ADDRESS (TV, STATE_ZIP CODE         CONTR         CONTR<	Minnesc	ta Department of H	lealth			1 Oran	AITROVED
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orders were issued. The following complaint was found to be SUBSTANITATED: HE185092, however NO licensing orders were issued. 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.	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
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