DEPARTMENT OF HEALTH AND HUMA	AN SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICE			
MEDIC	D TRANSMITTAL	ID:	RPBE		
PART I	- TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facil	ity ID: 00149	
1. MEDICARE/MEDICAID PROVIDER NO.	3. NAME AND ADDRESS OF FACILITY	ATION CENTED	4. TYPE OF ACTION:	<u>7</u> (L8)	

1. MEDICARE/MEDICAID PROVIDER NO.3. NAME AND ADDRESS OF FACILITY(L1)245223(L3) BAY VIEW NURSING & REHAB2.STATE VENDOR OR MEDICAID NO.(L4) 1412 WEST FOURTH STREET(L2)955270700(L5) RED WING, MN				REHABILI		ENTER	 4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 		
					()	·	7. On-Site Visit 9. Other		
 5. EFFECTIVE DATE CHANGE OF OWN (L9) 02/01/2019 	EKSHIP	7. PROVIDER/SU 01 Hospital	05 HHA	0RY 09 ESRD	<u>02</u> (L' 13 PTIP	7) 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 3/31/2020 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF		FISCAL YEAR ENDING DATE: (L35) 12/31		
	110 (L18) 110 (L17)		nce With equirements b Based On: cceptable POC		2. Te 3. 24 4. 7-1	eroved Waivers Of echnical Personnel Hour RN Day RN (Rural SN fe Safety Code	The Following Requirements: 6. Scope of Services Limit 7. Medical Director F) 8. Patient Room Size 9. Beds/Room		
13.Total Certified Beds	10 (L17)		pliance with Prog and/or Applied V		* Code: A		(L12)		
14. LTC CERTIFIED BED BREAKDOWN		•			15. FACILITY	Y MEETS			
18 SNF 18/19 SNF 110	19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK 17. SURVEYOR SIGNATURE	S (IF APPLICA	Date :	NCELLATION I	DATE):	18. STATE SU	URVEY AGENCY	APPROVAL Date:		
Karen Aldinger, Unit Super			/15/2020	(L19)			th Program Representative 4/15/2020 (L20)		
	II - TO BE						TATE AGENCY		
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partic	ipate		RIGHTS ACT: 2. Ownership/Con				nancial Solvency (HCFA-2572) trol Interest Disclosure Stmt (HCFA-1513) we :		
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE 23	. LTC AGREEN	MENT 24	. LTC AGREEM	IENT	26. TERMIN	NATION ACTION:	(L30)		
OF PARTICIPATION 11/01/1978	BEGINNINC	B DATE	ENDING DAT	Έ	VOLUNTARY 01-Merger, Cl				
(L24)	(L41)		(L25)			tion W/ Reimburse	· · · · · · · · · · · · · · · · · · ·		
25. LTC EXTENSION DATE: 27		VE SANCTIONS n of Admissions:	(1.44)			oluntary Termination on for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active		
(L27)	B. Rescind Su	uspension Date:	(L44) (L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARK	S			
		06201							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE					
((L32)			(L33)	DETERMI	NATION APPF	ROVAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 15, 2020

Administrator Bay View Nursing & Rehabilitation Center 1412 West Fourth Street Red Wing, MN 55066

RE: CCN: 245223 Cycle Start Date: January 30, 2020

Dear Administrator:

On March 30, 2020, we forwarded the results of the survey completed on March 11, 2020 to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On April 13, 2020 and March 26, 2020 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 10, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 19, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 10, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 19, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 10, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>



Electronically delivered April 15, 2020

CMS Certification Number (CCN): 245223

Administrator Bay View Nursing & Rehabilitation Center 1412 West Fourth Street Red Wing, MN 55066

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 10, 2020 the above facility is certified for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPARTMENT OF HEALTH AND HUMA	N SERVICES	CENTERS FOR MEDI	CARE & MEDICAID SERVICES
MEDIC	ARE/MEDICAID CERTIFICATION AN	ND TRANSMITTAL	ID: RPBE
PART I -	TO BE COMPLETED BY THE STATE	E SURVEY AGENCY	Facility ID: 00149

2.STATE VENDOR OR MEDICAID NO. (L2) 955270700	3. NAME AND ADDRESS OF FACILITY (L3) BAY VIEW NURSING & REHABII (L4) 1412 WEST FOURTH STREET (L5) RED WING, MN	(L6) 55066 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint				
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 02/01/2019	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 01/30/2020 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual06 PRTF10 NF03 SNF/NF/Distinct07 X-Ray11 ICF/III04 SNF08 OPT/SP12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31			
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:					
From (a): To (b):	A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of	6. Scope of Services Limit 7. Medical Director			
12.Total Facility Beds 110 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SN				
13.Total Certified Beds 110 (L17)	 B. Not in Compliance with Program Requirements and/or Applied Waivers: 	5. Life Safety Code * Code:	9. Beds/Room (L12)			
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS				
18 SNF 18/19 SNF 19 SNF 110	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38) (L39)	(L42) (L43)					
6. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):						
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:			
Mary Beth Lacina, HFE NE II	02/24/2020 (L19)	Ka <u>mala Fiske-Downing, Heal</u>	th Program Representative 03/02/2020 (L20)			
PART II - TO BE	COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE S	TATE AGENCY			
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
	RIGHTS ACT:	2. Ownership/Contro	l Interest Disclosure Stmt (HCFA-1513)			
1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	RIGHTS ACT:		l Interest Disclosure Stmt (HCFA-1513)			
 Facility is Eligible to Participate Facility is not Eligible 		2. Ownership/Contro	l Interest Disclosure Stmt (HCFA-1513)			
1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	MENT 24. LTC AGREEMENT	 Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (HCFA-1513) : (L30)			
1. Facility is Eligible to Participate 2. Facility is not Eligible (L21) (L21) 22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNIN	MENT 24. LTC AGREEMENT	2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u>	l Interest Disclosure Stmt (HCFA-1513) : 			
	MENT 24. LTC AGREEMENT G DATE ENDING DATE (L25) IVE SANCTIONS n of Admissions:	2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure	I Interest Disclosure Stmt (HCFA-1513) : (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement n <u>OTHER</u> 07-Provider Status Change			
1. Facility is Eligible to Participate 2. Facility is not Eligible 2. Facility is not Eligible 1. Each end of the end o	MENT 24. LTC AGREEMENT G DATE ENDING DATE (L25) IVE SANCTIONS n of Admissions: (L44) uspension Date:	2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio	I Interest Disclosure Stmt (HCFA-1513) (L30) (L30) (D5-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement n <u>OTHER</u>			
1. Facility is Eligible to Participate 2. Facility is not Eligible 2. CL21) 22. ORIGINAL DATE OF PARTICIPATION BEGINNIN 11/01/1978 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNAT A. Suspension (L27) B. Rescind S	MENT 24. LTC AGREEMENT G DATE ENDING DATE (L25) IVE SANCTIONS n of Admissions: (L44)	2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio	I Interest Disclosure Stmt (HCFA-1513) : (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement n <u>OTHER</u> 07-Provider Status Change			
1. Facility is Eligible to Participate 2. Facility is not Eligible 2. CL21) 22. ORIGINAL DATE OF PARTICIPATION BEGINNIN 11/01/1978 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNAT A. Suspension (L27) B. Rescind S	MENT 24. LTC AGREEMENT G DATE ENDING DATE (L25) IVE SANCTIONS n of Admissions: (L44) uspension Date: (L45)	2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	I Interest Disclosure Stmt (HCFA-1513) : (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement n <u>OTHER</u> 07-Provider Status Change			
1. Facility is Eligible to Participate 2. Facility is not Eligible 2. CL21) 22. ORIGINAL DATE OF PARTICIPATION BEGINNIN 11/01/1978 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNAT A. Suspension (L27) B. Rescind S	MENT 24. LTC AGREEMENT G DATE ENDING DATE (L25) IVE SANCTIONS n of Admissions: (L44) uspension Date: (L45) 9. INTERMEDIARY/CARRIER NO.	2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	I Interest Disclosure Stmt (HCFA-1513) : (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement n <u>OTHER</u> 07-Provider Status Change			
	MENT 24. LTC AGREEMENT G DATE ENDING DATE (L25) IVE SANCTIONS n of Admissions: (L44) uspension Date: (L45) 9. INTERMEDIARY/CARRIER NO. 06201	2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	I Interest Disclosure Stmt (HCFA-1513) : (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement n <u>OTHER</u> 07-Provider Status Change			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 10, 2020

Administrator Bay View Nursing & Rehabilitation Center 1412 West Fourth Street Red Wing, MN 55066

RE: CCN: 245223 Cycle Start Date: January 30, 2020

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On January 30, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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

Bay View Nursing & Rehabilitation Center February 10, 2020 Page 2

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.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us Phone: (651) 201-3794

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 the respective deficiencies (if any) is acceptable.

Bay View Nursing & Rehabilitation Center February 10, 2020 Page 3

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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 30, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 30, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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:

Bay View Nursing & Rehabilitation Center February 10, 2020 Page 4 https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OM	<u>IB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (СОМ	E SURVEY IPLETED
		245223	B. WING _			C 01/30/2020	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	• 17	00/2020
BAY VIE	W NURSING & REHA	BILITATION CENTER			12 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00			
E 026 SS=C	Preparedness Required January 27 through recertification survers compliance with the Preparedness Required Prepared	ver Declared by Secretary	E 02	26			3/17/20
	develop and implem policies and proceed plan set forth in para assessment at para and the communica this section. The p be reviewed and up (annually for LTC).]	bocedures. The [facilities] must nent emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must bodated at least every 2 years At a minimum, the policies list address the following:]					
	[facility] under a wa in accordance with provision of care ar	7), or (9)] The role of the iver declared by the Secretary, section 1135 of the Act, in the nd treatment at an alternate by emergency management					
	procedures. (8) The waiver declared by with section 1135 o at an alternative ca management officia	03.748(b):] Policies and e role of the RNHCI under a the Secretary, in accordance f Act, in the provision of care re site identified by emergency als. NT is not met as evidenced					
	Based on interview	/ and document review, the ure their emergency			The plan and response to CMS 256 written solely to maintain certification		
LABORATOR	L Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE
Electron	ically Signed						02/19/2020

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.

PRINTED: 02/27/2020

		AND HUMAN SERVICES			FORM): 02/27/2020 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED C
		245223	B. WING		01	/30/2020
NAME OF	PROVIDER OR SUPPLIER	L	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	/00/2020
BAY VIE	W NURSING & REHA	BILITATION CENTER			412 WEST FOURTH STREET ED WING, MN 55066	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026 E 032 SS=C	the role of the facilit the Secretary, in act the Act, (a waiver d regulatory requirem provide needed car in the provision of c alternate care site i management officia affect all 90 resider facility. Findings include: The facility policy a preparedness, revis address the role of waiver by declared When interviewed of safety and security facility emergency p procedures did not 1135 waiver. Primary/Alternate M CFR(s): 483.73(c)([(c) The [facility] mu emergency prepare that complies with F and must be review 2 years (annually fo plan must include a (3) Primary and alte communicating with (i) [Facility] staf	ies and procedures addressed ty under a waiver declared by cordance with section 1135 of esigned to waive specific nents in order to more easily re in an emergency situation) care and treatment at an dentified by emergency als. This had the potential to ats, staff and visitors at the nd procedures for emergency sed April 2019, failed to the facility under a 1135 by the Secretary. on 1/30/20, at 12:23 p.m. director (SSD)-A verified the oreparedness plan and address operation under a Means for Communication 3) ust develop and maintain an edness communication plan Federal, State and local laws ved and updated at least every or LTC).] The communication all of the following:	EC		Medicare and Medical Assistance Programs. These written responses do not constitute an admission of non-compliance with any requirement or an agreement with any findings. We wish to preserve the right to dispute these findings in there entirety should any remedies be imposed without jeopardizing the right to challenge it validity of the F-tags and without admitting that any non compliance with this regulation exists. We have implemented the following measures: The Emergency Preparedness Policy and Procedure (1135 - Declared Emergency) has been reviewed and revised to included the facilities roles and responsibilities as it relates to the(1135 Waiver - Federally Declared Emergency) Person Responsible: Maintenance Director	9

If continuation sheet Page 2 of 45

		AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		C		
		245223	B. WING _			30/2020		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BAY VIEV	W NURSING & REHAI	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 032	Continued From pa emergency manage	•	E 03	2				
E 037	alternate means for ICF/IID's staff, Fede local emergency ma This REQUIREMEN by: Based on interview facility failed to ensu- preparedness common primary and alterna with staff and Feder local emergency ma had the potential to in the facility. Findings include: The facility Emerge Procedure, revised communication plan means of communi tribal, regional, and management agence contact list and proce submitted. When interviewed of safety and security plan and procedure means of communi Federal, State, triba emergency manage EP Training Program	nunication plan included te means for communicating ral, State, tribal, regional, and anagement agencies. This affect all patients 90 residents ncy Preparedness Plan and April 2019, did not include a n that included alternative cation with Federal, State, local emergency cies. A staff communication cedure was requested but not on 1/30/20, at 12:23 p.m. director (SSD)-A verified the did not include alternate cation with staff, clients, al, regional, and local ement agencies. m	E 03	 **The Emergency Communication Preparedness Plan has been develoand complies with Federal State and Local Laws. **The Emergency Preparedness Pla been revised to include a communic plan including primary and alternate means for communicating with the following: facility staff, federal, state regional, and local emergency management agencies. Person Responsible: Maintenance Director 	d an has cation	3/17/20		
SS=C	CFR(s): 483.73(d)(

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING	i			C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 037	*[For RNCHIs at §4 Hospitals at §482.1 at §484.102, "Organ OPOs at §486.360, Training program. T following: (i) Initial training policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) Provide eme- at least every 2 yea (iii) Maintain do preparedness traini (iv) Demonstrate emergency procedu (v) If the emerg and procedures are [facility] must condu policies and proced *[For Hospices at §- hospice must do all (i) Initial training policies and proced hospice employees services under arra expected roles. (ii) Demonstrate emergency procedu (iii) Provide eme- at least every 2 yea (iv) Periodically emergency prepare employees (includir special emphasis p	03.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs nizations" under §485.727, RHC/FQHCs at §491.12:] (1) The [facility] must do all of the g in emergency preparedness lures to all new and existing poiding services under volunteers, consistent with their ergency preparedness training rs. cumentation of all emergency ng. te staff knowledge of ures. ency preparedness policies e significantly updated, the uct training on the updated ures. 418.113(d):] (1) Training. The of the following: g in emergency preparedness lures to all new and existing , and individuals providing ngement, consistent with their e staff knowledge of ures. ergency preparedness training	E	037			

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING			C 01/30/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(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
E 037	others. (v) Maintain doo preparedness traini (vi) If the emerg and procedures are hospice must condu- policies and proced *[For PRTFs at §44 program. The PRTF (i) Initial training policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial th preparedness traini (iii) Demonstrate emergency procedu (iv) Maintain do preparedness traini (v) If the emerg and procedures are PRTF must conduc policies and proced *[For LTC Facilities Program. The LTC following: (i) Initial training policies and proced staff, individuals pro- arrangement, and v expected role. (ii) Provide eme- at least annually.	cumentation of all emergency ing. gency preparedness policies e significantly updated, the uct training on the updated lures. 41.184(d):] (1) Training F must do all of the following: g in emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their raining, provide emergency ing every 2 years. te staff knowledge of ures. ocumentation of all emergency ing. pency preparedness policies e significantly updated, the et training on the updated lures. at §483.73(d):] (1) Training facility must do all of the g in emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their ergency preparedness training output of all emergency	E	037			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING			C 01/30/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	 (iv) Demonstrate emergency procedu *[For CORFs at §48 CORF must do all of (i) Provide initial preparedness polici and existing staff, in services under arra consistent with their (ii) Provide emergency 2 yea (iii) Maintain do (iv) Demonstrate emergency procedu be oriented and asso responsibilities emergency plan wit workday. The training instruction in the loo systems and signal (v) If the emergency and procedures are CORF must conduct policies and procedus *[For CAHs at §485 The CAH must do a (i) Initial training policies and procedus and where necessan personnel, and gue cooperation with authorities, to all ne individuals providing 	te staff knowledge of ires. 35.68(d):](1) Training. The of the following: I training in emergency ies and procedures to all new ndividuals providing ngement, and volunteers, r expected roles. ergency preparedness training rs. cumentation of the training. ie staff knowledge of ires. All new personnel must signed specific regarding the CORF's hin 2 weeks of their first ng program must include cation and use of alarm is and firefighting equipment. gency preparedness policies e significantly updated, the et training on the updated ures. .625(d):] (1) Training program.	EC	037			

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		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 0 FORMAF OMB NO. 09	PROVED	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245223	B. WING			01/30/2020		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BAY VIE	W NURSING & REHAI	BILITATION CENTER			412 WEST FOURTH STREET ED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE C	(X5) OMPLETION DATE	
E 037	at least every 2 yea (iii) Maintain do (iv) Demonstrate emergency procedu (v) If the emer and procedures are CAH must conduct policies and proced *[For CMHCs at §4 CMHC must provid preparedness polic and existing staff, ir under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This REQUIREMEN by: Based interview an failed to train new a providing services u volunteers regardin for the facility emer (EPP). This had the residents in the faci visitors. Findings include: The facilities emerg 2019, identified, "St the facility's emerge procedures upon hi	ergency preparedness training rs. cumentation of the training. te staff knowledge of ures. rgency preparedness policies e significantly updated, the training on the updated ures. 85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new individuals providing services , and volunteers, consistent	E	037	** Emergency Preparedness Poli Procedure have been reviewed at revised to all new and existing em contracted employees. **New Employee Orientation Eme Preparedness will be topic on th agenda. ** New Department communication at each unit will contain tab for Em Preparedness fact sheet. **Audit Orientation records for con every month. Initially audit all emp records for attendance at Emerge preparedness Training. **Person Responsible: Maintenar Director & Staff Development Dire	nd aployees, ergency e on book nergency mpliance oloyee ency		

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED	
	245223		B. WING			C 01/30/2020	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(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
E 037	training that demon emergency plan an existing staff, as we services under arra During interview on registered nurse (R received facility spe demonstrated know preparedness polic During interview on assistant (NA)-E sta facility specific train knowledge of the fa policies and proced During interview on stated they had not training that demon facilty emergency p procedures. During interview on and language patho not received facility demonstrated know preparedness polic During interview on	 htation of initial and annual strated knowledge of the d procedures for all new and ell as individuals providing ingement and volunteers. 1/29/30, at 6:59 a.m. N)-G stated they had not ecific training that vledge of the facilty emergency ies and procedures. 1/29/30, at 7:43 a.m. nursing ated they had not received ing that demonstrated acilty emergency preparedness lures. 1/29/30, at 8:30 a.m. NA-F received facility specific strated knowledge of the areparedness policies and 1/29/30, at 8:47 a.m. speech blogist (SLP)-A stated they had specific training that vledge of the facilty emergency ies and procedures. 1/29/30, at 8:47 a.m. speech blogist (SLP)-A stated they had specific training that vledge of the facilty emergency ies and procedures. 1/30/20, at 12:23 p.m. safety 	E)37			
E 039	and security director had not conducted preparedness traini annually that demon facility's emergency procedures.	or (SSD)-A verified the facility documented emergency ing for staff on orientation or instrated staff knowledge of the preparedness plan and	EC)39			3/17/20

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED C
		245223	B. WING				30/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039 SS=C	• · · · · · · · · · · · · · · · · · · ·	-	EC	039			
	HHAs at §484.102, "Organizations" unc	03.748, ASCs at §416.54, CORFs at §485.68, OPO, der §485.727, CMHC at HC at §491.12, ESRD 2]:					
	 (2) Testing. The [fact to test the emergen must do all of the formunity-based equation (i) Participate in community-based equation (A) When a not accessible, comexercise every 2 (B) If the [fanatural or man-mactivation of the emission exempt from engression of the emission exercise formunity-based of functional exercise the actual event. (ii) Conduct an every 2 years, opport functional exercise this section is conditioned exercise this section is conditioned exercise; (B) A second community-based of functional exercise (B) A mock (C) A tablet is led by a facilitation discussion using a clinically-releval 	cility] must conduct exercises acy plan annually. The [facility] blowing: In a full-scale exercise that is every 2 years; or a community-based exercise is duct a facility-based functional years; or acility] experiences an actual de emergency that requires hergency plan, the [facility] laging in its next required or individual, facility-based exercise following the onset of additional exercise at least osite the year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: Ind full-scale exercise that is or individual, facility-based ; or disaster drill; or top exercise or workshop that r and includes a group narrated, int emergency scenario, and a ements, directed messages, or					

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
l		245223	B. WING _			C 30/2020
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
	W NURSING & REHA	BILITATION CENTER		1412 WEST FOURTH STREET		
				RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	emergency plan. (iii) Analyzer maintain documenta exercises, and emer revise the [facility's] *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in community based e (A) When a not accessible, com- based functional ex (B) If the ho or man-made emer of the emergency p exempt from engag scale community-based f the onset of the em (ii) Conduct an years, opposite the functional exercise this section is condu- not limited to the fol (A) A seco- community-based of exercise; or (B) A mock (C) A table is led by a facilitator discussion using a clinically-releva	e the [facility's] response to and ation of all drills, tabletop ergency events, and emergency plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: n a full-scale exercise that is every 2 years; or a community based exercise is duct an individual facility tercise every 2 years; or ospice experiences a natural gency that requires activation lan, the hospital is jing in its next required full ased exercise or individual functional exercise following ergency event. additional exercise every 2 year the full-scale or under paragraph (d) (2)(i) of ucted, that may include, but is llowing: nd full-scale exercise that is or a facility based functional c disaster drill; or top exercise or workshop that r and includes a group narrated, nt emergency scenario, and a ements, directed messages, or	E 03	39		

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING _			C 30/2020
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAR	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	care directly. The h exercises to test the year. The hospice f (i) Participate in that is community-b (A) When a not accessible, con- facility-based function (B) If the ho- or man-made emer of the emergency p exempt from engag full-scale communit functional of the emergency e (ii) Conduct an that may include, but following: (A) A secon community-based of exercise; or (B) A mock (C) A table by a facilitator that i using a narrated, emergency scenario statements, directed questions des emergency plan. (iii) Analyze the maintain documenta exercises, and emergency the hospice's emergency	ices that provide inpatient hospice must conduct e emergency plan twice per must do the following: n an annual full-scale exercise ased; or community-based exercise is duct an annual individual onal exercise; or ospice experiences a natural gency that requires activation lan, the hospice is ing in its next required y based or facility-based exercise following the onset vent. additional annual exercise ut is not limited to the nd full-scale exercise that is or a facility based functional c disaster drill; or top exercise or workshop led ncludes a group discussion clinically-relevant o, and a set of problem d messages, or prepared signed to challenge an e hospice's response to and ation of all drills, tabletop	E 03	39		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING _		01/3	C 30/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	§482.15(d), CAHs a (2) Testing. The [PF conduct exercises t twice per year. The do the following: (i) Participate in that is community-b (A) When a not accessible, com facility-based function (B) If the [P experiences an actu emergency that req emergency plan, the engaging in its next based or functional exercise emergency event. (ii) Conduct an and that may includ following: (A) A secor community-based of functional exercise; (B) A mock (C) A tablet is led by a facilitator discussion, using a clinically-releva set of problem state prepared questions emergency plan. (iii) Analyze the maintain documenta exercises, and eme	At §485.625(d):] RTF, Hospital, CAH] must o test the emergency plan a [PRTF, Hospital, CAH] must in an annual full-scale exercise ased; or a community-based exercise is duct an annual individual, onal exercise; or RTF, Hospital, CAH] ual natural or man-made uires activation of the e [facility] is exempt from required full-scale community individual, facility-based following the onset of the [additional] annual exercise or e, but is not limited to the ad full-scale exercise that is or individual, a facility-based or disaster drill; or op exercise or workshop that and includes a group narrated, nt emergency scenario, and a ements, directed messages, or designed to challenge an [facility's] response to and ation of all drills, tabletop ergency events and revise gency plan, as needed.	Ε 0	39		

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		245223	B. WING				30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	 (2) The [LTC facility test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in that is community-be (A) When a not accessible, confacility-based function (B) If the [L] an actual natural or requires activation of the LTC facility is exrequired a full-scale individual, facili following the onset (ii) Conduct an that may include, bu following:	 must conduct exercises to plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: n an annual full-scale exercise based; or a community-based exercise is duct an annual individual, onal exercise. TC facility] facility experiences man-made emergency that of the emergency plan, xempt from engaging its next e community-based or ty-based functional exercise of the emergency event. additional annual exercise ut is not limited to the emergency event. additional annual exercise that is or an individual, facility based for a community-based or ty-based functional exercise of the emergency event. additional annual exercise that is or an individual, facility based for a individual, facility based for an individual, facility based for an individual facility ba based for an indit based for an indit based fo	EC	139			

Facility ID: 00149

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245223	B. WING _			C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	 (2) Testing. The ICF to test the emergen The ICF/IID must di (i) Participate in that is community-be (A) When a not accessible, comfacility-based function (B) If the IC natural or man-mace activation of the emergency e (ii) Conduct an may include, but is (A) A secor community-based functional exercise; (B) A mock (C) A tablet is led by a facilitator discussion, using a clinically-releva set of problem state prepared questions emergency plan. (iii) Analyze the maintain document exercises, and emergency at §486 (d)(2) Testing. The following: 	F/IID must conduct exercises acy plan at least twice per year. o the following: n an annual full-scale exercise based; or a community-based exercise is duct an annual individual, onal exercise; or. CF/IID experiences an actual de emergency that requires hergency plan, the ICF/IID aging in its next required ty-based or individual, facility- al exercise following the onset event. additional annual exercise that not limited to the following: not full-scale exercise that is or an individual, facility-based g or disaster drill; or top exercise or workshop that r and includes a group narrated, int emergency scenario, and a ements, directed messages, or designed to challenge an e ICF/IID's response to and ation of all drills, tabletop ergency events, and revise gency plan, as needed.	E 03	39		

	H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245223	B. WING	i			C 30/2020
NAME OF PROVIDER OR SUPPLIE	۲		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIEW NURSING & REH	ABILITATION CENTER			12 WEST FOURTH STREET ED WING, MN 55066		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
 is led by a facilita discussion, using emergency scena statements, or questions design plan. If the OPO of or man-made em of the emergency engaging in its ne following the onse (ii) Analyze th maintain docume and emergency e and OPO's] emer This REQUIREM by: Based on intervie facility failed to er preparedness exe community based full scale commut top exercise were emergency prepa potential to affect facility. Findings include: The facilities emer updated April 201 addition to the es program, Bay Vie Center shall cond simulations at lea accordance with a federal guidelines The facility provide 	ast annually. A tabletop exercise	EO		**The Safety Committee will meet a 2-27-2020 and determine the date for table top exercise. ** The Maintenance Director will als contact the County Emergency Management Director to discuss the county wide exercise for this year. After completion of a Community ba exercise, an after action review will completed to identify deficiencies in plan. Person Responsible: Maintenance Director	for a so e ased be	

Facility ID: 00149

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245223	B. WING				30/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	had been conducte was requested. Hay scale community ba not provide evidence attempted to partici based exercise. When interviewed of safety and security facility had not conde emergency prepare year. INITIAL COMMENT Bay View Nursing a Special Focus Faci recertification surve Complaint investiga Your facility was fou with the requiremer Subpart B, Require Facilities.	and Rehabilitation Center is a lity (SFF) and received a ey on 1/27/20 through 1/30/20. ations were also conducted. und not to be in compliance not s of 42 CFR Part 483, ements for Long Term Care	FC	000			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245223	B. WING _				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			2 WEST FOURTH STREET D WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	Continued From pa H5223178C.	ge 16	F 00	00			
	as your allegation o Department's accept bottom of the first p be used as verificat	·					
F 695 SS=D	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with ostomy Care and Suctioning	F 69	95			3/17/20
	The facility must en needs respiratory c care and tracheal s care, consistent wit practice, the compr care plan, the resid and 483.65 of this s This REQUIREMEN by: Based on observat review the facility fa agency)staff were the provide tracheostor opening in the neck	and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced ion, interview, and document illed to ensure pool (temporary rained and competent to my (tube inserted through an i into the windpipe) care and a residents (R41) reviewed for			F695 **R41 Depth of suctioning will be re-evaluated by Northwest Respirat and scale kept at bed side. R41 Ca has been updated to reflect the cha **All facility residents who require re or routine suctioning will also be re-evaluated by Northwest Respirat depth of suctioning and scale kept a bedside.	re plan inge. egular tory for	

Event ID: RPBE11

Facility ID: 00149

If continuation sheet Page 17 of 45

	OF DEFICIENCIES	& MEDICAID SERVICES	. ,	PLE CONSTRUCTION	(X3) DATI	0938-039		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED		
		245223	B. WING			C		
	PROVIDER OR SUPPLIER	243223	D. WING _	STREET ADDRESS, CITY, STAT		30/2020		
		BILITATION CENTER		1412 WEST FOURTH STREE				
				RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE		
F 695	Continued From pa	age 17	F 69	5				
	12/9/19, identified I required extensive support of two plus daily living (ADLs). R41's diagnoses of hypoxia (decreased body tissues), mort (trach) status. R41's care plan (C indicated R41 was related to impaired The CP instructed symptoms of hypo the ventilator settin via the trach. When interviewed stated pool staff do R41 stated one pool nurse (LPN)-F mad ago" during suction During observation LPN-C entered R4 and provide trach s gloves, vent was di oxygen placed to tr retrieved a suction alcohol based hand applied from suctio trach suctioned thr LPN-C then used a	himum Data Set (MDS) dated R41 was cognitively intact and physical assistance with persons for most activities of The MDS further identified f acute respiratory failure with d level of oxygen available for bid obesity, and tracheostomy P) last reviewed 1/18/20, ventilator (vent) dependent breathing mechanics at night. staff to assess for signs and kia. The CP further indicated gs and nebulizer treatments on 01/27/20, at 2:37 p.m. R41 onot perform proper trach care. of nurse, licensed practical de (R41) bleed, "not too long ning. on 1/29/20, at 8:11 a.m. 1's room to remove from vent suctioning. LPN-C applied isconnected, and humidified rach via trach dome. LPN-C kit, removed gloves, and used d rub (ABHR). Sterile gloves on kit. Balloon deflated and ee times. Balloon inflated. a Yankauer (suction tip) to N-C removed gloves and		**The process of how licensed staff was revi to include new compe **All licensed staff why tracheostomy resident prior to providing Trace Vent Care. **Resident requiring suctioning .* Nurses from the Agen additional training on Suctioning and Vent C Northwest Respiratory education/training to s tracheostomy care, su Care. Initiated 2-20-20 *Competency check li by staff development I with each new staff or working with any resid tracheostomy/care su **Education will be pro and new licensed staff working with tracheos **Competency checks current pool staff to er facility policy and proce **Audit will be complei initial training by (NWH Orientation, times 1 tra orientations, until 1000 determined by QAPI C ** Person responsible control/Staff developm	iewed and updated tency training. o work with ts receive education heostomy Care, & s with Trach's, those 'Both Licensed cy received Trach Care Care on 1-30 -2020* /(NWR) to complete taff regarding loctioning & Vent 020 st to be completed RN/RN Manager pool staff prior to lent requiring ctioning ovided for Pool staff f hired prior to tomy residents. a completed for all nsure compliance of ledure. ted weekly after R) and Bay View aining and 3 % compliance as Committee. : Infection			

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	01	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING					C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	E		
	W NURSING & REHAI			1	412 WEST FOURTH STREET			
DATVIE	W NURSING & REHAI	BILITATION CENTER		R	RED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
F 695	Continued From particle cuff prior to such needed suctioning a did not deflate the banything out with the lot [RN-D], he tol him. I told [RN-D] withat." R41's progress noted 3:08 a.m. indicated 1:00 a.m. Progress balloon before suct balloon prior to leave note further indicated 3:00 a.m. when R4 deflate the balloon when a stated the prior to succe [R41] has granulom do not deflate the cuff prior to succe [R41] has gran		F	895	DEFICIENCY)			
	[LPN-F] is a pool nu great down there w	urse and has been doing orking with [LPN-C]. I think " RN-B was also in the office						

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		AND HUMAN SERVICES				FORM	: 02/27/2020 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	CON	E SURVEY IPLETED C
		245223	B. WING	i			30/2020
	PROVIDER OR SUPPLIER W NURSING & REHA	BILITATION CENTER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066	• <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	and confirmed RN- in the office confirm manager did most of stated, "pool staff g prior to working the and stated, RN-A u at the facility and w infection control nu "[RN-A] is developi competency check scrape from the pre check off list and it change this." When interviewed of stated, "Packets for done before the firs would be responsib confirmed pool staff to their first shift from RN-D's competence located in RN-A's of worked with [RN-D] stated RN-D did no that shift. RN-A staff month or two and I working with me did them for me to com reported not feeling cares (vent/trach) in confirmed the facili documentation that training or that RN- previous training. When interviewed of pool staff agency of number and stated	age 19 D was a pool RN. LPN-D also ned the previous nurse of the vent training. LPN-D pet training from regular staff ir first shift. DON confirmed sed to be a nurse on the floor ras now the staff trainer and rse. DON further stated, ng a training program. The off is pretty weak. We had to evious person. We had a was not accurate. We have to on 1/30/20, at 8:30 a.m. RN-A r pool are supposed to be st shift. They come in early. I ble to check them off." RN-A ff were "checked off just prior om whatever staff is here." y checklist could not be office. RN-A stated, "I have I here before." RN-A further t perform vent/trach cares on ated, "[RN-D] has been here a know that when [RN-D] was d not do those skills and left hplete. RN-A stated [RN-D] g comfortable completing those ndependently. RN-A ty cannot produce any t RN-D received vent/trach D was competent from		695			

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIDI		FORM MB NO.	02/27/2020 APPROVED 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
		245223	B. WING				30/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIEW NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES					412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From pa	-	F	695			
		d the agency would send the tion competency checklist					
	confirmed not havir at the facility. RN-D of orientation prior t shift with LPN-C, bu how to suction or ca	on 1/30/20, at 1:20 p.m. RN-D ng specific vent/trach training confirmed having four hours to the start of first scheduled at the training did not include are for vents/tracheostomy's. med there was no checklist to encies.					
	indicated, "Suctionin every shift for excess distress to maintain number of times su	ministration record (TAR) ng: May suction as needed ssive secretions/respiratory airway; Document total ctioned each shift." R41's TAR tioned R41 once during the 20.					
	and Suction Compe checklist with speci checked off by a nu	Trach Stoma Care, Cleaning etency identified a competency fic steps to be observed and urse. RN-D's competency ested but not provided.					
	(Endotracheal or Tr identified the proce- in order to maintain infection. The polic supplies, what to as procedure for suction trach suctioning is a also indicated that to complications such	uctioning Lower Airway ach Tube) revised 3/14, dure for removing secretions an open airway and prevent y indicated the necessary sess, and step by step oning. The policy identified a sterile procedure. The policy here are possible as trauma to the airway, kia if the procedure was not					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED C
		245223	B. WING _			30/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIEW NURSING & REHABILITATION CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRECULATORY OF LSC INFORMATION TAG			(X5) COMPLETION		
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 695	Continued From pa	ge 21	F 69	15		
F 756 SS=D	revised 10/17, indic employed or contra facility-specific, con development and tr further indicated lice demonstrate specifi deemed necessary residents. The polic competency based contain specialized resident population Drug Regimen Rev CFR(s): 483.45(c)(1) §483.45(c) Drug Re §483.45(c)(1) The construction set and the reviewed a licensed pharmacis §483.45(c)(2) This of the resident's me §483.45(c)(4) The p irregularities to the facility's medical dir and these reports n (i) Irregularities inc drug that meets the (d) of this section fo (ii) Any irregularities during this review n separate, written re attending physician director and directo minimum, the resid	iew, Report Irregular, Act On 1)(2)(4)(5) egimen Review. drug regimen of each resident it least once a month by a t. review must include a review	F 75			3/17/20

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		AND HUMAN SERVICES				FORM /	02/27/2020 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (2	(X3) DATE SURVEY COMPLETED C		
		245223	B. WING	i			, 30/2020	
NAME OF	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE			
BAY VIEW NURSING & REHABILITATION CENTER					412 WEST FOURTH STREET RED WING, MN 55066			
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 756	resident's medical r irregularity has bee action has been tak be no change in the physician should do the resident's medic §483.45(c)(5) The f maintain policies ar drug regimen review limited to, time fram the process and ste when he or she ide requires urgent acti This REQUIREMEN by: Based on documen facility failed to add recommendations f reviewed for unnect Findings include: R30's quarterly Min assessment 11/25// diagnoses including disorder, and traum without loss of cons antipsychotic medic during the look bac reduction yet attem R30's physician ord milligrams (mg) of c antipsychotic medic	hysician must document in the record that the identified n reviewed and what, if any, the to address it. If there is to be medication, the attending bocument his or her rationale in cal record. Facility must develop and and procedures for the monthly with that include, but are not hes for the different steps in the pharmacist must take ntifies an irregularity that ion to protect the resident. NT is not met as evidenced ant review and interview, the	F	756	F756 **R30 s orders updated to include Orthostatic blood pressure monthly, Target behaviors and side effect monitoring for Seroquel. Care plan reviewed and updated. **Pharmacy Consultant Medication Review Policy and Procedure has be reviewed and updated to include how facility will respond to and follow up of recommendations. **RN Nurse Managers will identify ot residents on Psychotropics and implement monitoring for orthostatic pressures, targeted behaviors and si effect monitoring. **Nurse managers to review all phan recommendations and complete recommendations within consultants recommended time frame. **Audit will be completed monthly by	w the on ther blood ide macy		

Facility ID: 00149

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVE 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	CON	E SURVEY IPLETED	
		245223	B. WING		C 01/30/2020		
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
BAY VIEW NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 756	R30's Consultant P Review dated 12/20 facility, "add orders including patient sp effects, and orthost orders did not provi was monitoring R30 antipsychotic medic R30's sleep care pl R30's inability to sle the interventions wa doctor orders. Now the facility address or monitoring for sid behaviors. When interviewed of licensed practical n effect and target be the treatment admin nurses had to watch behaviors in reside medications during they saw any conce reviewed R30's ord for side effect or tar R30's TAR did not p effect/target behavior When interviewed of Pharmacist (Ph)-E December 2019, th to monitor R30 for s behaviors related to and noted the facility recommendation un visits to the facility i	harmacist's Medication D/19, recommended the for antipsychotic monitoring ecific target behaviors, side atic blood pressures." R30's ide evidence that the facility D for side effects related to cation use, or target behaviors. an initiated 11/13/19, noted eep well due to anxiety. One of as to give R30 quetiapine per here else on the care plan did the antipsychotic medication, de effects and target on 1/29/19, at 2:03 p.m. urse (LPN)-A stated that side shavior monitoring should be in nistration record (TAR), as the h for side effects and target nts taking antipsychotic their shift, and document if erns on the TAR. LPN-A ers and did not find an order rget behavior monitoring. orovide evidence of side or monitoring.	F 75	6 or designee for Pharmacy Revie responses & follow-up until 100 compliance completed is achiev determined by the QAPI commi ** Person responsible: DON or **Audits for residents being place Psychotropics or new admissions/re-admissions will b completed every 2 weeks x3 me until 100% Compliance as deter the QAPI Committee, ** Person responsible: Clinical Coordinators or Designee	% ved as ttee. designee ced on e onths or		

If continuation sheet Page 24 of 45

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245223	B. WING			C	
	PROVIDER OR SUPPLIER	243223	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	01/30/2020		
BAY VIEW NURSING & REHABILITATION CENTER				1412 WEST FOURTH STREET			
BAY VIE	W NURSING & REHAI	BILITATION CENTER		RED WING, MN 55066			
(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	
F 756	Continued From pa monitoring.	ge 24	F 7	56			
	11/27/19, included r pharmacist had rev regimen, and made needed to be review recommendations of	es dated 8/31/19, and notes that a different iewed R30's medication e recommendations that wed. The pharmacist's could not be located in the record. The recommendations not provided.					
	revised April 2014, review each resider least monthly, and t actual problems de and recommendation	acy Services procedure required the pharmacist to nt's medication regimen at to communicate potential or tected and document findings ons. This policy did not specify uld respond to and maintain					
F 757 SS=D	2017, required all re psychopharmacolog monitored for side e Drug Regimen is Fr	eview plan revised November esidents on a gical medication to be effects. ree from Unnecessary Drugs	F 7	57		3/17/20	
	Each resident's dru	ssary Drugs-General. g regimen must be free from . An unnecessary drug is any					
	§483.45(d)(1) In ex duplicate drug thera	cessive dose (including apy); or					
	§483.45(d)(2) For e	excessive duration; or					
1	1		1			1 1	

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391	
			• •			(X3) DATE SURVEY COMPLETED		
		245223	B. WING			C 01/30/2020		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BAY VIEW NURSING & REHABILITATION CENTER					412 WEST FOURTH STREET ED WING, MN 55066			
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 757	 §483.45(d)(4) With use; or §483.45(d)(5) In the consequences which reduced or disconting stated in paragraph section. This REQUIREMENT by: Based on interview facility failed to more for 1 of 2 residents an anticoagulant (b) Findings include: R13's significant chr (MDS) dated 10/25 cognitively intact ar assist of one for material (ADLs). R13's MDS of deep vein thromological perioder of the section of the s	out adequate monitoring; or out adequate indications for its e presence of adverse ch indicate the dose should be nued; or combinations of the reasons is (d)(1) through (5) of this NT is not met as evidenced v and document review, the nitor for potential side effects (R13) reviewed who received lood thinner) medication.	F 7	757	F757 *R13 orders and Plan of Care updat reflect Anticoagulation *monitoring. *All Inhouse residents on anticoagul medication are in process reviewed care plans updated, monitoring of si effects. *Nurse manager or designee to revi new admission orders to assure pro monitoring of anticoagulant medicat *Education on anticoagulants, Side effects, & *Audit will be completed monthly un 100% compliance completed is ach as determined by the QAPI committ ** Person responsible: Unit Clinical Coordinator	lant with ide ew oper ions. til ieved		
		on 1/27/20, at 1:18 p.m. R13 g a blood thinner daily and, "I						

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB NO	: 02/27/2020 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		PLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED C	
		245223	B. WING	i			/30/2020
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIEW NURSING & REHABILITATION CENTER					1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 757	licensed practical n resident is on a bloo bruising, and monit the TAR [treatment LPN-C opened a di medical record (eM anticoagulants were "discolored urine, b severe headache, N diarrhea, muscle jo energy and enthusi changes in mental SOB [shortness of l further stated the n of all anticoagulants LPN-C stated, "Onl TAR], TMAs [trained When interviewed of LPN-D confirmed a should be monitore on the TAR. Registo should be in the orc effects]." RN-B acc confirmed R13 was verified and stated, [the TAR] if we are There is no order in confirmed it would n provider because it used. Director of n stated, "Nurses sho resident is on an ar	ne two weeks ago." on 1/27/20, at 1:18 p.m. urse (LPN)-C stated when a od thinner, "We look for or other things. Can I look in administration record]?" fferent resident's electronic (R) and confirmed residents on e monitored for the following: lack tarry stools, sudden N&V [nausea and vomiting], int pain, lethargy [lack of asm], bruising, sudden status and/or V/S [vital signs], breath], nose bleeds." LPN-C urses monitor for side effects is including Eliquis and Xarelto. y the LPNs mark those [on the d medication aide] do not." on 1/30/20, at 8:02 a.m. nticoagulant side effects d every shift and documented ered nurse (RN)-B stated, "It ders [to monitor the side essed R13's eMR and taking Xarelto. RN-B further "It would have to be in here checking for side effects. n [R13's] chart." RN-B further not be a direct order from the is a template that the facility ursing (DON) verified and ould check side effects when a nticoagulant." DON further	F	757			
	supposed to be sel	r monitoring side effects was ected when the order for the entered into the eMR.					

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED
					LE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
						(C
		245223	B. WING			01/3	30/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIEW NURSING & REHABILITATION CENTER				412 WEST FOURTH STREET RED WING, MN 55066			
(X4) ID			ID				(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
	• •		, 				
F 757	Continued From pa	ige 27	F 7	'57			
	When interviewed of	on 1/30/20, at 9:16 a.m.					
	pharmacist confirm	ed side effects should be					
		dents taking Xarelto.					
		confirmed the protocol for effect monitoring should be					
		IR by the facility staff.					
		ary report as of 1/30/20, or 20 mg Xarelto with an order					
		r acute embolism (a blood clot,					
	foreign object, or ot	ther bodily substance that					
		a blood vessel) and thrombosis					
		ck part of the leg behind the 3's order summary report					
		e order for monitoring side					
	effects of the antico	bagulant.					
	R13's TAR for Dece	ember 2019 and January 2020					
		onitoring for side effects of an					
	anticoagulant.						
	The facility policy A	nticoagulation with Warfarin,					
		ght Heparin, or Lovenox					
	revised 11/14 identi	ified process for staff to					
		ations of anticoagulation					
		/ instructed staff to monitor for s hematuria (blood in the					
		(coughing up blood), and any					
	other evidence of b	-	I	_			
F 758		sychotropic Meds/PRN Use	F 7	'58			3/17/20
SS=D	CFR(s): 483.45(c)(3)(e)(1)-(5)					
	§483.45(e) Psychot						
		chotropic drug is any drug that					
		ies associated with mental avior. These drugs include,					
		to, drugs in the following					

Facility ID: 00149

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			PLETED
		245223	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER		. I		TREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	AY VIEW NURSING & REHABILITATION CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 758	Continued From pa	ae 28	F 7	58			
1 100	categories:	90 20		50			
	(i) Anti-psychotic;						
	(ii) Anti-depressant;(iii) Anti-anxiety; and						
	(iv) Hypnotic	u					
	Based on a compre	hensive assessment of a					
		must ensure that					
	§483.45(e)(1) Resid	dents who have not used					
		are not given these drugs					
		on is necessary to treat a signosed and documented					
	in the clinical record						
	§483.45(e)(2) Resid	dents who use psychotropic					
		ual dose reductions, and					
		tions, unless clinically an effort to discontinue these					
	drugs;						
	•	dents do not receive					
		pursuant to a PRN order tion is necessary to treat a					
		condition that is documented					
	in the clinical record	d; and					
		orders for psychotropic drugs					
		ys. Except as provided in					
		e attending physician or oner believes that it is					
	appropriate for the	PRN order to be extended					
		or she should document their dent's medical record and					
		n for the PRN order.					
	8483 45(e)(5) PRN	orders for anti-psychotic					
		14 days and cannot be					

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SU COMPLET C	
		245223	B. WING _				30/2020
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENTER			EST FOURTH STREET ING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) ROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 758	prescribing practitic the appropriateness This REQUIREMEN by: Based on document facility failed to ens psychotropic medic effects and target b (R30 and R77) revi medications. Findings include: R30's quarterly Mina assessment 11/25/ diagnoses including disorder, and traum without loss of cons antipsychotics on a antipsychotic medic days during the loo reduction yet attem R30's physician or milligrams (mg) of antipsychotic medic bedtime related to I mood affective disc R30's Consultant P Review dated 12/20 "add orders for anti patient specific targ orthostatic blood pr provide evidence th	 attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced nt review and interview, the ure residents taking rations were monitored for side behaviors for 2 of 5 residents ewed for unnecessary imum Data Set (MDS) 19, described R30 to have g mood disorder, mental natic subdural hemorrhage sciousness. R30 was taking routine basis, and received cations seven out of seven k back, with no gradual dose pted since admit 8/26/19. der dated 11/2/19, for 12.5 quetiapine fumarate, an cation, was to be given at R30's diagnosis of unspecified order. harmacist's Medication D/19, recommended the facility psychotic monitoring including get behaviors, side effects, and essures." R30's orders did not nat the facility was monitoring a related to antipsychotic 	F 75	F75 *R30 med corre mon inclu mon *All i med indic effec inclu chec *Nur new mon med *Auc moth achie com	D S psychopharmacologic lications have been reviewed ections made to include side itoring and target behaviors, ide orthostatic blood pressure	effect also to e checks ologic if lude side haviors, ire eview oroper gic x2 s API	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING	i			C 30/2020
NAME OF I	PROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
BAY VIE	W NURSING & REHAI	BILITATION CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 758	R30's sleep care pla R30's inability to sle the interventions wa doctor orders. Now the facility address or monitoring for sid behaviors. When interviewed of licensed practical n effect and target be the treatment admin nurses had to watch behaviors in resider medications during they saw any conce reviewed R30's ord for side effect or tar R30's TAR did not p effect/target behavi When interviewed of Pharmacist (Ph)-E December 2019, th to monitor R30 for s behaviors related to and noted the facility recommendation un visits to the facility i appropriate side eff monitoring. R77's quarterly MD included moderate diagnoses including and post traumatic an antipsychotic me during the look back	an initiated 11/13/19, noted eep well due to anxiety. One of as to give R30 quetiapine per here else on the care plan did the antipsychotic medication, de effects and target on 1/29/19, at 2:03 p.m. urse (LPN)-A stated side havior monitoring should be in histration record (TAR), as the h for side effects and target nts taking antipsychotic their shift, and document if erns on the TAR. LPN-A ers and did not find an order rget behavior monitoring. orovide evidence of side or monitoring. on 1/30/20, at 9:15 a.m. stated he recommended in e facility should add an order side effects and target o the antipsychotic medication, ty did not implement this ntil 1/29/20. Ph-E's monthly	F	758			

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING	i) 01/3	30/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	ambulate during the but needed extensi transfer. R77's Adm diagnoses of repea major depressive d features. R77's physician ord antipsychotic medic fumarate), at 300 m related to post traun also had orders for blood pressures (bl performed in succe then standing) mon month. Orthostatic drops in blood press laying down, to sittin The Seroquel Medi- Drug Administration side effect of taking pressure (orthostati lightheadedness or change in heart rate rising too quickly fro R77's transfers/mol described R77 to no in and out of bed, to toilet. The care plan for staff or would no would self transfer. had falls related to described R77 to bo medications, such a negative side effect	e seven day look back period, ve assist of two staff to hission Record form included ted falls, and recurrent severe isorder without psychotic der dated 7/5/19, for cation Seroquel (quetiapine ing each night before bed matic stress disorder. R77 staff to check orthostatic ood pressure checks ssion while laying, then sitting, thly on the 15th of every blood pressure measures for sure as a person moves from	F	758			

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	KS FOR MEDICARE	& MEDICAID SERVICES				<u>. 0938-039′</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	CON	E SURVEY IPLETED	
		245223	B. WING			C 30/2020	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
BAY VIE	W NURSING & REHA	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 758 F 836 SS=E	monthly orthostatic measurements on t did not document of the TAR in January and Vitals Summar orthostatic blood pr Interview on 1/30/2 explained his mont residents for side e confirmed orthostat part of side effect n antipsychotic medic ambulatory. The Psychopharma Assessment and R 2017, required all n psychopharmacolo monitored for side of License/Comply w/ CFR(s): 483.70(a)- §483.70(a) Licensu A facility must be lid and local law. §483.70(b) Complia Local Laws and Pro The facility must op compliance with all local laws, regulatic accepted professio	d a place for staff to document blood pressure the 15th of every month. Staff orthostatic blood pressure on 2020. Review of the Weights y showed the last documented ressure check on 12/15/19. 0, at 9:15 a.m. Pharmacist-E hly visits included reviewing ffect monitoring, and tic blood pressure checks were nonitoring for residents taking cations who may be acologic Medication eview plan revised November esidents on a gical medication to be effects. Fed/State/Locl Law/Prof Std (c) rre. censed under applicable State ance with Federal, State, and ofessional Standards. perate and provide services in applicable Federal, State, and ons, and codes, and with nal standards and principles isionals providing services in	F 758			3/17/20	

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION (COMF	E SURVEY PLETED
		245223	B. WING			01/3	30/2020
NAME OF F	PROVIDER OR SUPPLIER		ľ	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
BAY VIE	W NURSING & REHA	BILITATION CENTER			12 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 836	forth in this subpart the applicable provi regulations, includir pertaining to nondis race, color, or natio nondiscrimination of CFR part 84); nond age (45 CFR part 9 basis of race, color disability (45 CFR p subjects of researc and abuse (42 CFF individually identifia CFR parts 160 and provisions may resundance wit This REQUIREMEN by: Based on document facility failed to notifia registered sex off Findings include: R77's Admission Readmitted to the faci R77's quarterly Min assessment descrifi impaired cognition, post traumatic stress towards others for period, needing ext transfer, and extension	liance with the regulations set a, facilities are obliged to meet asions of other HHS ng but not limited to those corimination on the basis of anal origin (45 CFR part 80); on the basis of disability (45 iscrimination on the basis of 1); nondiscrimination on the astronal origin, sex, age, or part 92); protection of human h (45 CFR part 46); and fraud R part 455) and protection of ble health information (45 164). Violations of such other ult in a finding of th this paragraph. NT is not met as evidenced and review and interview, the fy 43 of 88 current residents of tender living in the facility. ecord form showed R77	F 8	36	F836 **R77 Care Plan updated to include attending activities involving minor children nor will be offered 1 to 1 visi involving minors. Observe that he is within reach of minor children and is to nurses station and in a private roc R77 Plan of Care changes will be communicated to all facility staff invo in his care. **All residents admitted after the initi notification regarding Bay View admit a sex offender will now receive a notification, as well as any future admissions. *Policy and Procedure developed an implemented for registered sex offer admitted and living in facility. *Sex Offender Notification forms and	its not close om. blved ial itting nd	

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLF			0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						C)
		245223	B. WING _			01/3	80/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENTER			412 WEST FOURTH STREET ED WING, MN 55066		
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIO DATE
F 836	Continued From pa	age 34	F 83	36			
		1/27/20, at 4:46 p.m. to			signature page given to current reside	ents	
		propel in the wheelchair			admitted since 8/7/18 and added to		
		n, out to the doorway of the ck into R77's room again.			admission procedure for potential admissions ongoing.		
					*Each signature page to be uploaded	into	
	R77's safety care p	blan dated 8/7/18, noted history			resident s electronic documentation		
		ense from 1993, involving			record		
		wn to R77. Interventions			** Social Services will be responsible	for	
		esidents of the facility on ing that R77 was not within			ensuring all residents are notified & documentation is present if sex offend	dore	
	reach or alone with				are admitted.	uers	
					**All residents since 8-18-19 will be		
		tes for the past three months			audited to ensure they have been noti	ified	
		vevidence that R77 was			regarding sex offender in facility.		
	other residents.	behaviors/aggression toward			**On going audits will be conducted, regarding notification of sex offenders	e in	
	other residents.				facility, every 2 weeks for new admiss		
	R77's medical reco	ord contained a Fact Sheet			unless otherwise determined by QAPI		
		form was self titled as,			Committee.		
		Registered Offender," and was			Person Responsible: Social Service		
		Facility Residents." Red Wing provided the Fact Sheet to the			Director or Designess		
		uant to Minnesota Statutes					
		This statute provided for the,					
		rmation on registered					
		assigned risk level to facility					
		/or facility residents." The Fact					
		77 as risk level two, with inal sex conduct (two counts) in					
		e children known to R77.					
		59 a.m. the director of social					
		ted R77 had not wandered into					
		rooms, touched people, or one else. DSS stated the					
		sent the Fact Sheet about					
	R77's convictions a	after R77 was already admitted					
		DSS personally distributed the					
	notice to every resi	ident and guardian at that time.					

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		AND HUMAN SERVICES				FORM	: 02/27/2020 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245223	B. WING				C /30/2020
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BAY VIE	W NURSING & REHA	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(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 SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 836	DSS described hav to ensure they unde Since 8/7/18, no ne notified of R77's co searched for R77 o name did not come described searching registry at the time from the police, and name at that time. I name multiple time found it, so despite confused about why registered offender residents. The current census (including two resid and 43 of those res- initial notification to A facility policy on a and notifying reside was requested, but on 1/30/20, that the policy. The Minnesota (MN Apprehension Pred website explained of conduct required re- risk level two indica re-offend. Furtherm registrants listed or to be non-complian report changes in a vehicles owned or of	ing conversations with people erstood what the notice meant. w admissions had been nvictions, because when staff n the online registry, R77's up. Registered nurse (RN)-E g for R77's name on an online of receiving the Fact Sheet d being unable to find R77's RN-E searched for R77's s on the online list, and never the Fact Sheet, RN-E was ether R77 was truly a requiring notification to all the a list included 88 residents ents currently in the hospital), idents were admitted after the ok place on 8/7/18. admitting registered offenders, not provided. RN-E confirmed e facility did not have such a A) Bureau of Criminal atory Offender Registration convictions of criminal sexual egistration in MN. Additionally, ited a moderate likelihood to nore, the website were considered t (when a registrant failed to ddresses, employment, operated, etc.). Therefore, the intended to be a complete list	F	336			

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	E SURVEY PLETED
		245223	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880 SS=D	Infection Prevention CFR(s): 483.80(a)(§483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys 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 t (i) A system of surve possible communic infections before the persons in the facilii (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pro-	a & Control 1)(2)(4)(e)(f) control tablish and maintain an a and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ions. a prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements: atem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment bg to §483.70(e) and following tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections;	F 8	80			3/17/20
	§483.80(a)(2) Writte procedures for the p but are not limited t (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 pro-	en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a					

		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM A	02/27/2020 PPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X		SURVEY LETED	
		245223	B. WING	;		01/30/2020		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BAY VIE	W NURSING & REHAI	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emplo- disease or infected contact with resider contact with resider contact will transmit (vi)The hand hygier by staff involved in §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must have transport linens so- infection. §483.80(f) Annual r The facility will cond IPCP and update the This REQUIREMEN by: Based on observate review, the facility fa follow contact preca (R13) reviewed for precautions. Findings include: R13's significant ch	ange Minimum Data Set	F	880	F880 **R-13 Is on contact isolation precaut His pressure wounds were cultured a the final results. A sign has been plac on his room door indicating contact precautions and for visitor to see nurs station prior to entering. C-diff precau had been removed a few weeks prior 1-27-2020.	ind ced se at itions		
	(MDS) dated, 10/25	5/19, identified R13 as ad required set up assist or			**There is one other resident (MB)wh	io is		

Facility ID: 00149

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OM		APPROVE 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	COM	E SURVEY PLETED	
		245223	B. WING	WING			C 30/2020	
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BAY VIE	W NURSING & REHA	BILITATION CENTER			412 WEST FOURTH STREET ED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 880	assist of one for ma (ADLs). R13's MDS osteomyelitis (infect (infection in the blocenterocolitis due to a bacterium that ca diarrhea of the colo condition in which t urine properly due to paraplegia (impaire of the lower extrem R13's order summa identified contact is resistant organism or other microorgar antibiotics). Contac for staff and visitors protect themselves During observation personal protective floor outside and to was no sign on R13 precautions. After permission to enter up." When interviewed of nursing assistant (N any precautions. When interviewed of license practical nu on contact precaution	any activities of daily living S further identified diagnoses tion in the bones), sepsis od), multiple pressure ulcers, clostridium difficile (C. diff is a n cause symptoms such as n), neurogenic bladder (a he bladder does not empty to nerve damage), and ad motor and sensory function ities). ary report dated 12/19/19 olation due to multiple drug (MDRO occurs when bacteria hisms become resistant to t isolation identifies a process to glove and gown in order to and other residents. on 1/27/20, at 1:08 p.m. equipment (PPE) was on the the left of R13's door. There 3's door identifying knocking and asking t, R13 stated, "You better gown on 1/27/20, at 1:21 p.m. NA)-D stated R13 was not on	F 8	80	on Droplet Precautions. There are s on her door indicating such. Reside Staff have been educated on Drople Precautions. **When other residents are identifie requiring Transmission based Preca that will be communicated at our da morning meeting. On weekend and hours the Bldgs. charge or supervis commuicate this information. There also a communication book now at station . All department staff working the unit are required to read this boo **Policy & Procedure for Contact Precautions has been reviewed and revised to reflect current standards practice. All Facility Staff will be educated on revised Policy & Procedure for Cont Precautions. **Facility will identify and follow com precautions. **Audits will be conducted with room isolation set up & staff adherence to correct precaution protocol. Once pr weekly x 8 weeks until 100% complia as determined by the QAPI Commit **Responsible Person: Infection Con Specialist /Designee	nt and et autions ily after or will is each g on ok. I of cact tact based n o er shift iance tee.		

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	-	AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G		E SURVEY PLETED
			A BOILD			(C
		245223	B. WING				30/2020
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
	W NURSING & REHAI	BILITATION CENTER			1412 WEST FOURTH STREET		
		BIEITANON GENTER			RED WING, MN 55066		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE
_					DEFICIENCY)		
F 880	Continued From pa	ge 39	F٤	380	C		
	precautions.						
	During observation	on 1/29/20, at 8:00 a.m. PPE					
		nd to the left of R13's door					
		autions sign was now					
	displayed on R13's	door.					
	During charminting						
		on 1/29/20, 11:14 a.m. 3's door with foot and then					
		peverages in hands. LPN-C					
		wn or gloves. LPN-C set					
		the bed side table. LPN-C					
		nd and pulled door closed with					
	either before or afte	and hygiene was performed					
		on 1/29/20, at 11:29 a.m.					
		assistant (TMA)-A entered					
		off cereal, bowl and milk. e or gown. TMA-A used					
		I rub (ABHR) prior to leaving					
		or closed with ungloved and					
	sanitized hand.						
	During choon ation	an 1/20/20 at 12:49 n m					
		on 1/29/20, at 12:48 p.m. 3's room to answer call light.					
		y gloves or gown. R13 stated					
		ied. LPN-C stated, "Ok, let					
		t." LPN-C stepped out of					
		plied gloves, gown and mask.					
		al, LPN-C removed PPE and c pulled door shut with					
	un-gloved and sanit						
	0						
		on 1/30/20, at 7:36 a.m.					
		e are just standing in the room					
		or dropping something off we n." LPN-C further stated that					
		the wounds. "So unless we					

If continuation sheet Page 40 of 45

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245223	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
	W NURSING & REHAD			1	412 WEST FOURTH STREET		
	W NURSING & RENAL	SILITATION CENTER		F	RED WING, MN 55066		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	LPN-C further state we are in there [R13 we do something, w up. But if we just end drinks, we do not h stated, "[R13] empt redirected to an ope collected in a bag] a catheter] into the unurinal. That is when glove or use my foo know what is on the When interviewed of director of nursing (necessary to gown on contact precaution linens or perform can when working direct should gown and gl hope there is not a contact precautions nursing station, for When interviewed of infection control nur- should be a sign on of precaution and w cannot go into a con gowning even if just Regardless of what staff were trained an precautions. The facility policy In Precautions were to precautions were to	ares we don't have to gown." ed, "It's sort of a gray area. If 3's room] and [R13] requests we come back out and gown neter to drop off Styrofoam have to gown." LPN-C further ies own colostomy [colon is ening on abdomen and and the Foley [urinary inal and then we empty the n I would gown. I usually of to open the door as I don't e handle." on 1/30/20, at 7:58 a.m. (DON) stated it was not and glove when someone is ons and staff do not touch the ares. DON further stated tly with the wound, staff love. DON further stated, "I sign on the door, [stating s]. It should just say check with dignity and such." on 1/30/20, at 8:23 a.m. rse RN-A stated, "There a the door to say what the type what PPE was needed. You ntact precautions room without t dropping something off. infection." RN-A further stated nnually on isolation 10/18, indicated contact o be in place for residents with		80			
		be in place for residents with dinfections that could be					

Facility ID: 00149

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		AND HUMAN SERVICES				FORM	02/27/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245223	B. WING				C 30/2020
NAME OF PROVIDER OR SUF	PLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIEW NURSING &	REHA	BILITATION CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
PREFIX (EACH DEFI	CIENC	TEMENT OF DEFICIENCIES Y 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
indirect conta resident care and visitors to The policy fur wear a dispos and to remove room. The po perform hand before leaving Influenza and CFR(s): 483.8 §483.80(d) In immunization §483.80(d) (1) policies and p (i) Before offe each resident receives educ potential side (ii) Each resident receives educ potential side (ii) Each resident receives educ potential side (ii) The resident has the opport (iv) The resident has the opport (iv) The resident has the opport (iv) The resident documentation following: (A) That the r was provided and potential immunization (B) That the r	y direc ct with items o wear ther in able g gow licy fu hygie g the n Pneu 30(d)(fluenz s Influe rocecor ring the rocecor ring the cation effect lent is Octol ess the ed or the cation n that eside g and eside or dice or dice or dice	t contact with resident or n environmental surfaces or . The policy instructed staff gloves when entering room. Instructed staff and visitors to gown upon entering the room n and gloves prior to leaving rther instructed staff to ene after removing gloves room. Imococcal Immunizations		380			3/17/20

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/27/2020 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE			E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			PLETED
		245223	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIEV	W NURSING & REHA	BILITATION CENTER			12 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 883	Continued From pa	ge 42	F٤	883			
	refusal.						
		mococcal disease. The facility es and procedures to ensure					
		resident or the resident's					
		ives education regarding the ial side effects of the					
	immunization, unles	offered a pneumococcal so the immunization is					
	already been immu	icated or the resident has nized; the resident's representative					
	has the opportunity	to refuse immunization; and nedical record includes					
	following:	indicates, at a minimum, the					
	was provided educa	nt or resident's representative ation regarding the benefits ffects of pneumococcal					
	immunization; and						
		nt either received the unization or did not receive					
		mmunization due to medical					
	This REQUIREMEN	NT is not met as evidenced					
	Based on documer	nt review and interview, the			F883 **R234 refused immunization and		
		r an influenza vaccination for 1 4) reviewed for immunizations.			documentation completed per facili policy, education provided to reside		
	Findings include:				consent received. **Facility will offer influenza &		
	admitted to the facil	Record form showed R234 ity 1/14/20. On the date of			Pneumococcal vaccine to all reside upon admission or request docume		
		gned a Resident/Patient ent or Declination form, giving			of completion prior to admission. Declination form to be signed if refu	isal of	

Facility ID: 00149

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U LITE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
		245223	B. WING _			C 30/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BAY VIE	W NURSING & REHA	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 883	consent to receive a signature indicated education of risk ar R234's Immunization medical record on a evidence that the fai influenza vaccine to record indicated the influenza vaccination During interview on director of nursing (residents to be offer throughout the entine facility intended to P onsite to offer resid throughout the entine doctor recommended The Centers for Dis (CDC) Vaccine Info 8/15/19, noted that around the United S between October a The facility policy, In Resident/Patient, Ia recognized the "mai influenza disease o and the effectivene health care costs a hospitalization and residents to be offer the flu vaccine annite	the influenza vaccine. The consent was given after and benefits had been provided. In Report from the electronic 1/30/20, did not provide acility had provided the or R234 since admission. The elast known historical on was given 3/27/16. In 1/30/20, at 2:02 p.m. the (DON) stated he expected ared the influenza vaccine re influenza (flu) season as the have enough of the vaccine lents the option of vaccination re season, or longer if the ed. Sease Control and Prevention ormation Statement dated influenza activity spreads States each year, usually	F 88	3 vaccine's. The Facility immunization poprocedure has been reviewe to include Offering on admiss Annual involvement from QA **Audit to be done of immuni 7 days of admission. **Audtits will be completed w admissions for Influenza vac Pneumococcal every week x until 100% as determined by **Responsible Person: Healt Coordinator or Designee	d and revised ion and PI zations within reekly on new cine and 2 months the QAPI	

If continuation sheet Page 44 of 45

		AND HUMAN SERVICES			FORM	02/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING			30/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BAY VIE	W NURSING & REHA	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883	Immunization statu determined prior to	ge 44 stober through March). s for each resident was to be vaccination, and then a nsent would occur prior to	F 88	3		

	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY
		245223	B. WING_		01/29/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K 00	00		
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.				
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.				
	Minnesota Depart Fire Marshal Divis Bay View - previou was found not in o requirements for p Medicare/Medicai 483.70(a). Life Sa edition of Nationa	d at 42 CFR, Subpart fety from Fire, and the 2012 I Fire Protection Association 101, Life Safety Code (LSC)				
	PLEASE RETURI CORRECTION F DEFICIENCIES (K-TAGS) TO:	N THE PLAN OF OR THE FIRE SAFETY				
	IF OPTING TO U	SE AN EPOC, A PAPER COPY F CORRECTION IS NOT		EPOC		
	OF THE PLAN O REQUIRED.					

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.

		& MEDICAID SERVICES	(VO) MU		NSTRUCTION		. 0938-0391 TE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MAIN BUILDING 01	CON	MPLETED
		245223	B. WING				/29/2020
AME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP COL WEST FOURTH STREET	DE	
AY VIEV	W NURSING & REHA	BILITATION CENTER			WING, MN 55066		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa 445 Minnesota St.,		K	000			
	St Paul, MN 55101						
	By email to: FM.HC.Inspections	s@state.mn.us					
	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INF	ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:					
	1. A description of to correct the defic	what has been, or will be, done ciency.					
	2. The actual, or p	roposed, completion date.					
	responsible for co	or title of the person rrection and monitoring to rence of the deficiency.					
	is a 3-story buildir building was cons original building w determined to be 1972, addition wa that was determin construction. In 1 to the west wing.	Center (new name Bay View) ng with a partial basement. The tructed at 3 different times. The ras constructed in 1965 and was of Type II(222) construction. In is constructed to the West Wing ned to be of Type II(222) 999 a small addition was added Because the original building					
	and the 2 addition construction and allowed for existin surveyed as one	n are of the same type of meet the construction type ng buildings, the facility was building.					
	system. The facil	otected by a full fire sprinkler ity has a fire alarm system with the detection and spaces open to the monitored for automatic fire cation					

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SI	
	F CORRECTION	IDENTIFICATION NUMBER:		6 01 - MAIN BUILDING 01	COMPLE	ETED
		245223	B. WING		01/29/	/2020
AME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
AY VIEV	V NURSING & REHA	BILITATION CENTER	1	1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETIO DATE
K 000	Continued From pa	age 2	K 00	0		
	The facility has a c census of 87 at the	apacity of 130 beds and had a time of the survey.				
K 345 SS=D	NOT MET as evide Fire Alarm System	- Testing and Maintenance	K 34	5	3	/17/20
	A fire alarm system accordance with a with the requirement Electric Code, and and Signaling Cod acceptance, main available. 9.6.1.3. 9.6.1.5. N	- Testing and Maintenance n is tested and maintained in n approved program complying ents of NFPA 70, National I NFPA 72, National Fire Alarm le. Records of system tenance and testing are readily FPA 70, NFPA 72 ENT is not met as evidenced				
	Based on observation facility failed to ma fire alarm system	ation and staff interview, the aintain clear accessibility to the in accordance with the Life A 101 - 2012 edition (9.6.1.3, NFPA 72)		K345: During Walk-through of the facility observed obstructed access to fire pull station. *Correction: **Items removed form the pull stat	alarm	
	This deficient practice	This deficient practice could affect 87 residents.		signs will be placed to remind sta others to not stack supplies in the	aff and se	
	Findings Include: On facility tour be on 01/29/2020, of revealed the follo	tween 08:00 AM and 12:00 PM oservations and staff interview wing:		areas. Responsible Person: Maintenance Director	9	
	obstructed acces	ugh of the facility observed s to fire alarm pull-station(ADING DOCK AREA)				

Facility ID: 00149

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		E SURVEY
D PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	PLETED
		245223	B. WING	01/	29/2020
AME OF F	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
BAY VIEV	W NURSING & REHA	BILITATION CENTER	1	412 WEST FOURTH STREET RED WING, MN 55066	
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 345	Continued From pa		K 345		
K 252	discovery.	e Director at the time of Maintenance and Testing	K 353		3/17/20
	CFR(s): NFPA 101	Maintenance and resting	i coo		
	Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Maint Protection System maintenance, insp maintained in a se available.	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked			
	b) Who provided	-			
	Provide in REMAR any non-required o system. 9.7.5, 9.7.7, 9.7.8, This REQUIREME	KS information on coverage for partial automatic sprinkler			
	facility failed to ma clearances in acco	ation and staff interview, the aintain fire sprinkler head ordance with the Life Safety 2012 edition (9.7.5, 9.7.7, 25)		FM observed high storage in proximity of sprinkler heads on 3E and basement freezer *Correction: **Items removed from top of cabinets and shelving in freezer lowered so items woul	Ł
		ctice could affect 87 residents.		not obstruct fire sprinkler Responsible Person: Maintenance	
	Findings Include: On facility tour be on 01/29/2020, ok revealed the follow	tween 08:00 AM and 12:00 PM oservations and staff interview		Director/Designee	

Facility ID: 00149

If continuation sheet Page 4 of 11

ENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			OMB NO. 0	
TEMENT		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	COMPL	ETED
		245223	B. WING		01/29)/2020
	ROVIDER OR SUPPLIER	243225		STREET ADDRESS, CITY, STATE, ZIF	CODE	
				1412 WEST FOURTH STREET		
AY VIEV	V NURSING & REHA	BILITATION CENTER		RED WING, MN 55066		
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE	(X5) COMPLETIO DATE
K 353	Continued From pa	age 4	K 3	53		
К 355	(1) High storage outside of RM 2-20 (2) Obstructed sp (BASEMENT) This deficient prac Facility Maintenan discovery.	orinkler heads in walk-in freezer otice was confirmed by the ce Director at the time of	КЗ	355		3/17/20
SS=D	CFR(s): NFPA 10 Portable Fire Exti Portable fire extin inspected, and m NFPA 10, Standa Extinguishers. 18 3 5 12 19 3 5	1 nguishers guishers are selected, installed, aintained in accordance with rd for Portable Fire 12, NFPA 10				
	This REQUIREM by: Based on observe facility failed to mextinguishers in a Code NFPA 101 10) This deficient prati- Findings Include On facility tour b on 01/29/2020, or revealed the follow During walk-through	ENT is not met as evidenced vation and staff interview, the aaintain clear accessability to fire accordance with the Life Safety - 2012 edition (19.3.5.12, NFPA actice could affect 87 residents. : etween 08:00 AM and 12:00 PM observations and staff interview		K355 *Items blocking the fire where removed from loo place to inform staff and materials in this area. * Monthly audits will be Month of March and Ap compliant safety comm discontinue audits. *Person responsible: M Director	cation and signs d other not to store conducted for the ril and if 100% ittee will	

Facility ID: 00149

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		& MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. (X3) DATE	
ATEMENT (D PLAN OF	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		PLETED
		245223	B. WING			9/2020
AME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIEW	V NURSING & REHA	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(FACH 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 355	Continued From pa	age 5	K 35	5		
	Facility Maintenand	tice was confirmed by the ce Director at the time of				
K 511 SS=D			K 51	1		3/17/20
	complies with NFF electrical wiring an NFPA 70, National	as or related gas piping A 54, National Fuel Gas Code, Ind equipment complies with I Electric Code. Existing Intinue in service provided no				
	by: Based on observ facility failed to ma accordance with t	ENT is not met as evidenced ation and staff interview, the aintain utilities access security in he Life Safety Code NFPA 101 - 5.1.1, 9.1.1, 9.1.2, NFPA 70)		K511 During walk through FM found electrical panel door in corrido *Correction: **Secured panel door contact	or 2E ed	
	This deficient practice could affect 87 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 01/29/2020, observations and staff interview revealed the following:			maintenance personal to dou panel doors after contractors electric doors or any other tim contractor have to access ele panels for service. Responsible Person: Mainten Director/Designee	work on the les ctrical	
	During walk-throu unsecured electr adjacent to RM 2	ugh of the facility observed - ical panel in the resident corridor -203 (2ND FL)	r			
	This deficient pra Facility Maintena	actice was confirmed by the nce Director at the time of				

Facility ID: 00149

If continuation sheet Page 6 of 11

ENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	SURVEY
ATEMENT (D PLAN OF	OF DEFICIENCIES CORRECTION			E CONSTRUCTION 01 - MAIN BUILDING 01		PLETED
		245223	B. WING		01/2	29/2020
AME OF P	ROVIDER OR SUPPLIER	I		TREET ADDRESS, CITY, STATE, ZIP CODE		
		BILITATION CENTER	532	12 WEST FOURTH STREET ED WING, MN 55066		
				PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLÉTIC DATE
K 511	Continued From pa	age 6	K 511			
	discovery.					2/17/20
K 521 SS=F	HVAC CFR(s): NFPA 101		K 521			3/17/20
	HVAC Heating, ventilation comply with 9.2 an accordance with th specifications. 18.5.2.1, 19.5.2.1,					
	by: Based on observ facility's general v system (HVAC) is	ENT is not met as evidenced ations and staff interviews, the entilating and air conditioning not installed and tested in he LSC, Section 19.5.2.1 and on 3-4.7.		K521 Annual Waiver for HVAC to be by John Donham Responsible Person: Maintena Director/Designee		
	This deficient pra-	ctice could affect 87 residents.				
	Findings Include: On facility tour be on 01/29/2020, of revealed the follo	tween 08:00 AM and 12:00 PM oservations and staff interviews wing:				
	floors in the 1965	estem on the 1st, 2nd, and 3rd addition utilizes the egress turn air for the resident rooms. (SUBMITTED)				
	This deficient pra	actice was confirmed by the nce Director at the time of				
	discovery.					

Facility ID: 00149

		& MEDICAID SERVICES	1			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
	245223		B. WING	B. WING		
IAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENTER		412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (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)	ILD BE	(X5) COMPLETIC DATE
K 712	Continued From pa	ige 7	K 712			
SS=F						
	signal and simulatic conditions. Fire drill unexpected times u least quarterly on e with procedures an established routine between 9:00 PM a announcement may alarms. 19.7.1.4 through 19 This REQUIREMEN by: Based on document the facility failed to conducting fire drills Safety Code NFPA through 19.7.1.7) This deficient pract Findings Include: On facility tour betw on 01/29/2020, obs reviewed revealed During documentat provided to confirm Q3 2019 (3rd shift This deficient pract	NT is not met as evidenced nt review and staff interview, maintain consistancy in s in accordance with the Life 101 - 2012 edition (19.7.1.4 ice could affect 87 residents. ween 08:00 AM and 12:00 PM servation and documentation		K712 During Documentation review FM no records were provided to con drills conducted on Q3 2019 (3rd and Q4 2019(1st Shift). *Correction: **Fire drills will be reviewed durir monthly QAPI/Safety meetings to conducted properly. Responsible Person: Maintenand Director/Designee	firm fire shift) ng wo ensure	
K 761	discovery. Maintenance, Inspe	ection & Testing - Doors	K 761			3/17/20

Facility ID: 00149

If continuation sheet Page 8 of 11

		AND HUMAN SERVICES		-	FORM	APPROVED 0938-0391
			TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED	
		245223	B. WING		01/2	29/2020
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
DAVVIE		BILITATION CENTER		1412 WEST FOURTH STREET		
DAT VIE	W NORSING & REHA	BIEITATION GENTER		RED WING, MN 55066		
(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)	DBE	(X5) COMPLETION DATE
K 761	Continued From pa	age 8	K 7	61		
	Fire doors assemble annually in accordation for Fire Doors and Non-rated doors, in patient rooms and routinely inspected maintenance program testing possess known that demonstrates Written records of maintained and an 19.7.6, 8.3.3.1 (LS 5.2, 5.2.3 (2010 N This REQUIREME by: Based on observation facility failed to maintained the doors in accord Code NFPA 101 - (LSC), 5.2, 5.2.3 (C) This deficient prace Findings Include: On facility tour be on 01/29/2020, other revealed the follow During walk-throut following: (1) Fire rated do top of the door > 1 (2) Smoke Barrin 2ND FL exhibited (3) Smoke Barrin	hing the door inspections and lowledge, training or experience ability. inspection and testing are e available for review. SC) FPA 80) ENT is not met as evidenced ation and staff interview, the aintain smoke barrier and fire ordance with the Life Safety 2012 edition (19.7.6, 8.3.3.1 2010 NFPA 80)) Etice could affect 87 residents. tween 08:00 AM and 12:00 PM observations and staff interview wing: ligh of the facility observed the or (#52) exhibited a gap at the 3/8" (2ND FL) er doors located on 1ST and		K761 1.During walk through FM found top of door #52 >3/8 **Correction: Door is being evaluated for repain 2.During walk through FM found barrier doors exhibited gaps>1/4 close **Correction: Bulb seals will be placed in all set barrier doors to close gap<1/4 3.FM found smoke barrier door of did not close and latch properly **Correction: Replace door hardware Responsible Person: Maintenan Director/Designee	irs smoke after noke on 3E PT ce	et Page 9 of 1

Facility ID: 00149

If continuation sheet Page 9 of 11

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		O	/IB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED	
		245223	B. WING		01/29/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BAY VIE	W NURSING & REHA	BILITATION CENTER		1412 WEST FOURTH STREET RED WING, MN 55066	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTIO
K 761	Continued From pa Area)	ge 9	K 76′		
K 920 SS=F	Facility Maintenanc discovery. Electrical Equipment	ice was confirmed by the e Director at the time of nt - Power Cords and Extens	K 92(3/17/20
	Extension Cords Power strips in a pa used for componer patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power st may not be used for electronics), excep rooms that do not u PCREE meet UL 1 strips for non-PCR (outside of vicinity) care rooms, power standards. All pow precautions. Exter substitute for fixed Extension cords us immediately upon of which it was install 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3(I This REQUIREME by: Based on observa facility failed to pro accordance with th	atient care vicinity are only atient care vicinity are only atient care vicinity are only atient care vicinity are only atient care vicinity are only delectrical equipment es that have been assembled nel and meet the conditions of rips in the patient care vicinity or non-PCREE (e.g., personal t in long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL rer strips are used with general asion cords are not used as a wiring of a structure. sed temporarily are removed completion of the purpose for ed and meets the conditions of 0, 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 NT is not met as evidenced tion and staff interview, the perly use electrical devices in the Life Safety Code NFPA 101 - .4., 10.2.3.6 (NFPA 99), 10.2.4		K920 1. During walk through FM observe following: (1) appliance connected power strip nursing office and busin	to

Event ID: RPBE21

Facility ID: 00149

If continuation sheet Page 10 of 11

TEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		Gonoritaerien	(X3) DATE SURVEY COMPLETED 01/29/2020	
		245223					
	ROVIDER OR SUPPLIER	BILITATION CENTER		14	REET ADDRESS, CITY, STATE, ZIP CODE 12 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
К 920	(NFPA 99), 400-8 (70), TIA 12-5) This deficient prace Findings Include: On facility tour bet on 01/29/2020, ob revealed the follow During walk-throug following: (1) Appliance con Nurses Office (1S (2) 6-plex electric duplex in Beauty S (3) Power strips FL) (4) Appliance con Business Office - This deficient prace	INFPA 70), 590.3(D) (NFPA tice could affect 87 residents. ween 08:00 AM and 12:00 PM servations and staff interview ving: gh of the facility observed the nnected to power-strips the ST FL) cal adapter inserted to wall		920	office. **Correction: 2. Unplugged the appliance and plu directly to outlet, education to be pri to all staff on proper use of power se During walk through FM found dais of power strip on 1st floor owners of **Correction: Removed additional power strip fro office, education to be provided to on proper use of power strips. 3. During walk through FM found 6p plugged into outlet in nurse coordin office on 2E **Correction: Removed 6 plex Education to be provided to all stat what is authorized to be used in th according to state. Responsible Person: Maintenance Director/Designee	rovided strips. by chain office om all staff plex nators ff on re facility	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 10, 2020

Administrator Bay View Nursing & Rehabilitation Center 1412 West Fourth Street Red Wing, MN 55066

Re: State Nursing Home Licensing Orders Event ID: RPBE11

Dear Administrator:

The above facility was surveyed on January 27, 2020 through January 30, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Bay View Nursing & Rehabilitation Center February 10, 2020 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Karen Aldinger, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us Phone: (651) 201-3794

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Bay View Nursing & Rehabilitation Center February 10, 2020 Page 3

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minneso	ta Department of He	ealth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		. ,		(X3) DATE COMP	SURVEY LETED
		00149		B. WING		01/3	C 0/2020
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	RILITATION CENT		T FOURTH \$ 6, MN 55066			
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2 000	Initial Comments			2 000			
	****ATTEI	NTION*****					
	NH LICENSING	CORRECTION ORDI	ER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has	ssued on, it is cited violation dance rule of been ag below. re to idered upon ule will the item				
	that may result from orders provided tha the Department with	hearing on any asses n non-compliance with it a written request is hin 15 days of receipt ent for non-compliance	n these made to of a				
	Department's staff	TS: 1/30/19, surveyors o visited the above prov tion orders are issued	vider and				
		int investigations were ne of the licensing su					
Minnesota D	epartment of Health						·
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENT	ATIVE'S SIGN	IATURE	TITLE		(X6) DATE 02/19/20

Electronically Signed

STATE FORM

If continuation sheet 1 of 27

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	00149 ^E		B. WING	B. WING		C 30/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
			ST FOURTH S	TREET		
BAY VIE	W NURSING & REHA	BILITATION CENT RED WIN	IG, MN 55066			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
TAG			TAG	DEFICIEN		27112
2 000	Continued From no	22.1	2 000			
2 000	Continued From pa	ige i	2 000			
		complaint's H5223171C,				
	-	3173C, H5223174C,				
		3170C, H523178C and				
	H5223176C was co	ompleted. The complaint's				
	were not substantia	ated.				
	An investigation of complaints H5223177C and H5223179C was completed. The complaints					
	H5223179C was completed. The complaints were substantiated but no correction orders were					
	issued at State Lice	ensing.				
	The Minnesota Dev	partment of Health is				
		tate Licensing Correction				
		al software. Tag numbers have				
		linnesota state statutes/rules				
		. The assigned tag number				
		eft column entitled " ID Prefix				
		atute/rule out of compliance is				
		nary Statement of Deficiencies'	•			
		es the "To Comply" portion of				
		r. This column also includes				
		are in violation of the state				
	•	atement, "This Rule is not met				
		ollowing the surveyors findings				
		Method of Correction and				
	Time period for Co					
		p participate in the electronic				
	•	ensure orders consistent with				
	the Minnesota Dep					
		tin 14-01, available at				
		tate.mn.us/divs/fpc/profinfo/inf				
		e licensing orders are				
	delineated on the a					
		Ith orders being submitted to				
		Although no plan of correction				
		ate Statutes/Rules, please				
		rected" in the box available for				
		indicate in the electronic				
	State licensure pro	cess, under the heading				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		C 01/30/2020	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	• -	
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH			
	SUMMARY STA		IG, MN 5506	6 PROVIDER'S PLAN OF CORREC		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
		e date your orders will be lectronically submitting to the nent of Health.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES				
2 005	MN Rule 4658.001 REGULATIONS AN	5 COMPLIANCE WITH ND STANDARDS	2 005			3/17/20
	services in complia state, and local law and with accepted l	ist operate and provide ance with all applicable federal 's, regulations, and codes, professional standards and y to professionals providing ng home.	,			
	by: Based on documen facility failed to noti	ent is not met as evidenced It review and interview, the fy 43 of 88 current residents of fender living in the facility.	F	Corrected		
	Findings include:					
	R77's Admission Readmitted to the faci	ecord form showed R77 lity 8/3/18.				
		imum Data Set (MDS) bed R77 as having moderately	,			

STATE FORM

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C C 00149 B. WING C 01/30/2020		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00149 B. WING 01/30/2020 MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14/42 WEST FOURTH STREET RED WING, MN 55066 COUNTLY STATE, ZIP CODE 14/42 WEST FOURTH STREET RED WING, MN 55066 COUNTLY CONTREST PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D 2 005 Continued From page 3 10 PREFIX TAG 2 005 Continued From page 3 2 005 Impaired cognition, diagnoses of dementia and post traumatic stress disorder, physical behaviors towards others for 1-3 days during the look back period, needing extensive assist of two staff to transfer, and extensive assist of two staff to used others. 2 005 R77 was observed 1/27/20, at 4:46 p.m. to independently self propel in the wheelchair around R77's room, out to the doorway of the room, and then back into R77's room again. R77's safety care plan date 8/7/18, noted history of a level II sex offense from 1993, involving minor females known to R77. Interventions included notifying residents of the facility on 8/7718, and observing that R77 was not within reach or alone with minors. R77's progress notes for the past three months did not provide any evidence that R77 was Here works				A. BUILDING: _			
BAY VIEW NURSING & REHABILITATION CEIN 1412 WEST FOURTH STREET RED WING, MN 55066 (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 CORRECTIVE ACTION REGULION ES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION REGULION E (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION REGULION E (EACH DEFICIENCY) (xx) (CMPLE DATE 2 005 Continued From page 3 impaired cognition, diagnoses of dementia and post traumatic stress disorder, physical behaviors towards others for 1-3 days during the look back period, needing extensive assist of two staff to transfer, and extensive assist of one for locomotion throughout the building using a wheelchair. 2 005 R77 was observed 1/27/20, at 4:46 p.m. to independently self propel in the wheelchair around R77's room, out to the doorway of the room, and then back into R77's norm again. R77's safety care plan dated 8/7/18, noted history of a level II sex offense from 1993, involving minor females known to R77. Interventions included notifying residents of the facility on 8/7/18, and observing that R77 was not within reach or alone with minors. R77's progress notes for the past three months did not provide any evidence that R77 was Id		00149		B. WING			
BAY VIEW NURSING & REHABILITATION CEN1 RED WING, MN 55066 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OERCETIVE ACTION SHOULD BE OCONSERVED TO THE APPROPRIATE DEFICIENCY) COMPLET CONSERVED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE 2 005 Continued From page 3 2 005 impaired cognition, diagnoses of dementia and post traumatic stress disorder, physical behaviors towards others for 1-3 days during the look back period, needing extensive assist of two staff to transfer, and extensive assist of two staff to transfer, and extensive assist of one for loccomotion throughout the building using a wheelchair. R77 was observed 1/27/20, at 4:46 p.m. to independently self propel in the wheelchair around R77's room, out to the doorway of the room, and then back into R77's room again. R77's safety care plan dated 8/7/18, noted history of a level II sex offense from 1993, involving minor females known to R77. Interventions included notifying residents of the facility on 8/7/18, and observing that R77 was not within reach or alone with minors. R77's progress notes for the past three months did not provide any evidence that R77 was	NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 2 005 Continued From page 3 2 005 impaired cognition, diagnoses of dementia and post traumatic stress disorder, physical behaviors towards others for 1-3 days during the look back period, needing extensive assist of two staff to transfer, and extensive assist of one for locomotion throughout the building using a wheelchair. 2 005 Impaired cognition, diagnoses of dementia and post traumatic stress disorder, physical behaviors towards others for 1-3 days during the look back period, needing extensive assist of two staff to transfer, and extensive assist of two staff to transfer, and extensive assist of one for locomotion throughout the building using a wheelchair. Impaired cognition, diagnoses of dementia and post transfer, and extensive assist of two staff to transfer, and extensive assist of one for locomotion throughout the building using a wheelchair. Impaired cognition, diagnoses are assisted the assist of two staff to the doorway of the room, and then back into R77's room again. Impaired cognition, diagnoses are assisted to the doorway of the room, and then back into R77. Interventions included notifying residents of the facility on 8/7/18, and observing that R77 was not within reach or alone with minors. Impaired cognition, diagnoses are assisted to the facility on 8/7/18, and observing that R77 was Impaired cognitic context assisted to the facility on 8/7/18, and observing that R77 was	(X4) ID		TEMENT OF DEFICIENCIES	-			
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		post traumatic strest towards others for period, needing ext transfer, and extens locomotion through wheelchair. R77 was observed independently self p around R77's room room, and then bac R77's safety care p of a level II sex offer minor females know included notifying re 8/7/18, and observi reach or alone with R77's progress note did not provide any	as disorder, physical behaviors 1-3 days during the look back ensive assist of two staff to sive assist of one for out the building using a 1/27/20, at 4:46 p.m. to propel in the wheelchair , out to the doorway of the sk into R77's room again. Ian dated 8/7/18, noted history inse from 1993, involving wn to R77. Interventions esidents of the facility on ng that R77 was not within minors. es for the past three months evidence that R77 was				
Police Department provided the Fact Sheet to the		nursing home pursu 243.166 Subd. 4b. "Distribution of infor offenders with an a	uant to Minnesota Statutes This statute provided for the, rmation on registered ssigned risk level to facility				
nursing home pursuant to Minnesota Statutes 243.166 Subd. 4b. This statute provided for the, "Distribution of information on registered offenders with an assigned risk level to facility administration and/or facility residents." The Fact		Sheet classified R7 conviction for crimin	7 as risk level two, with nal sex conduct (two counts) in e children known to R77.				

PRINTED: 02/27/2020 FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
00149 E		B. WING			C 30/2020	
AME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY, ST	TATE, ZIP CODE		
	W NURSING & REHA	BILITATION CENT 1412 WE	ST FOURTH S	TREET		
		RED WIN	IG, MN 55066			
X4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 005	Continued From pa	age 4	2 005			
	any other resident i gotten close to any police department a R77's convictions a to the facility, and I notice to every resi DSS described hav to ensure they und Since 8/7/18, no ne notified of R77's co searched for R77 c name did not come described searchin registry at the time from the police, and name at that time. name multiple time found it, so despite confused about wh	ted R77 had not wandered into rooms, touched people, or one else. DSS stated the sent the Fact Sheet about after R77 was already admitted DSS personally distributed the dent and guardian at that time. ving conversations with people erstood what the notice meant. ew admissions had been onvictions, because when staff on the online registry, R77's e up. Registered nurse (RN)-E of receiving the Fact Sheet d being unable to find R77's RN-E searched for R77's es on the online list, and never the Fact Sheet, RN-E was ether R77 was truly a requiring notification to all the				
	(including two resident and 43 of those resident the second secon	s list included 88 residents dents currently in the hospital), sidents were admitted after the sok place on 8/7/18.				
	and notifying reside was requested, but	admitting registered offenders, ents of registered offenders t not provided. RN-E confirmed e facility did not have such a				
	Apprehension Prec website explained of conduct required re	N) Bureau of Criminal datory Offender Registration convictions of criminal sexual egistration in MN. Additionally, ated a moderate likelihood to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED C
		00149	B. WING		01/30/2020	
ME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AY VIEV	W NURSING & REHA	BILITATION CENT	GT FOURTH			
X4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 005	Continued From pa	ge 5	2 005			
	to be non-complian report changes in a vehicles owned or o online list was not in of every registered	the website were considered t (when a registrant failed to ddresses, employment, operated, etc.). Therefore, the ntended to be a complete list offender.				
	administator or des policies and proced registered sex offer notification for all re with a registered se or desginee could a appropriate notifica resident representa administrator or des	ignee could review and revise lures related to admission of nders, and the required esidents residing in the facility ex offender. The administrator audit all residents to ensure tion to residents, and/or tives or guardians. The signee could develop policy would ensure appropriate				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 300	MN Rule 4658.010	5 Competency	2 300			3/17/20
	are able to demons techniques necessa needs, as identified resident assessment	ist ensure that direct care staff trate competency in skills and ary to care for residents' I through the comprehensive nts and described in the n of care, and are able to ned duties.				
	by: Based on observati review the facility fa agency)staff were t	ent is not met as evidenced on, interview, and document ailed to ensure pool (temporary rained and competent to my (tube inserted through an		Corrected		

If continuation sheet 6 of 27

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00149	B. WING			C 30/2020
	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
		1412 WE	ST FOURTH S			
BAY VIE	W NURSING & REHA	BILITATION CENT RED WIN	IG, MN 55066			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 300	Continued From pa	ige 6	2 300		,	
		c into the windpipe) care and 3 residents (R41) reviewed for ion/tracheostomy.				
	Findings include:					
	12/9/19, identified F required extensive support of two plus daily living (ADLs). R41's diagnoses of hypoxia (decreased body tissues), mort (trach) status.	imum Data Set (MDS) dated R41 was cognitively intact and physical assistance with persons for most activities of The MDS further identified acute respiratory failure with d level of oxygen available for bid obesity, and tracheostomy				
	indicated R41 was related to impaired The CP instructed symptoms of hypox	P) last reviewed 1/18/20, ventilator (vent) dependent breathing mechanics at night. staff to assess for signs and da. The CP further indicated gs and nebulizer treatments				
	stated pool staff do R41 stated one poo	on 01/27/20, at 2:37 p.m. R41 not perform proper trach care ol nurse, licensed practical le (R41) bleed, "not too long ing.				
	LPN-C entered R4 ² and provide trach s gloves, vent was di oxygen placed to tr retrieved a suction alcohol based hand applied from suctio	on 1/29/20, at 8:11 a.m. 1's room to remove from vent suctioning. LPN-C applied sconnected, and humidified ach via trach dome. LPN-C kit, removed gloves, and used d rub (ABHR). Sterile gloves n kit. Balloon deflated and ee times. Balloon inflated.				

Minnesc	ota Department of He	ealth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00149	B. WING	WING		C 30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH S IG, MN 55066			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
2 300	Continued From pa	ige 7	2 300			
	suction mouth. LPI washed hands.	N-C removed gloves and				
	stated, "I think it wa the cuff prior to suc needed suctioning a did not deflate the k anything out with th I told [RN-D], he tol	on 1/29/20, at 9:02 a.m. R41 as a pool nurse, did not deflate tioning." R41 further stated, "I and [registered nurse (RN)-D] balloon and did not get be suction." R41 stated, "When d me I am supposed to remind ou are supposed to know				
	3:08 a.m. indicated 1:00 a.m. Progress balloon before suct balloon prior to leav note further indicate 3:00 a.m. when R4	e by RN-D dated 1/29/20, at R41 requested suctioning at s note included, RN-D deflated ioning resident and inflated ving R41's room. The progress ed RN-D checked on R41 at 1 told RN-D that RN-D did not before suctioning last time.				
	LPN-C stated, "You the cuff prior to suc [R41] has granulom do not deflate the c	on 1/29/20, at 01:14 p.m. I don't always have to deflate ttioning but with [R41] you do. has [growth] forming and if you suff first you can either not ck them and cause bleeding."				
	director of nursing (recently experience stated the previous of the vent/trach tra therapist from the fa- vendor also supplie stated RN-A was th able to provide mor Pool staff would wo	on 1/30/20, at 7:43 a.m. (DON) stated the facility ed some staff turnover. DON nurse manager provided most anining to staff. A respiratory acility's contracted respiratory ed some training to staff. DON he new trainer and would be re information about training. ork with regular staff nurses stated, "We would not put	t			

TATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDEITH IOMINICATION DEIX.	A. BUILDING:			
		00149	B. WING		C 01/30/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH S NG, MN 55066			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 300	Continued From pa	age 8	2 300			
	[LPN-F] is a pool n great down there w [RN-D] is pool staff and confirmed RN- in the office confirm manager did most stated, "pool staff of prior to working the and stated, RN-A u at the facility and w infection control nu "[RN-A] is developi competency check scrape from the pro- check off list and it change this." When interviewed stated, "Packets for done before the firs would be responsit confirmed pool stat to their first shift fro RN-D's competence located in RN-A's of worked with [RN-D stated RN-D did no that shift. RN-A stat month or two and I working with me dif them for me to con reported not feeling cares (vent/trach) i	e without experience or alone. urse and has been doing vorking with [LPN-C]. I think f." RN-B was also in the office -D was a pool RN. LPN-D also ned the previous nurse of the vent training. LPN-D get training from regular staff eir first shift. DON confirmed used to be a nurse on the floor vas now the staff trainer and urse. DON further stated, ing a training program. The c off is pretty weak. We had to evious person. We had a t was not accurate. We have to on 1/30/20, at 8:30 a.m. RN-A for pool are supposed to be st shift. They come in early. I ble to check them off." RN-A ff were "checked off just prior om whatever staff is here." cy checklist could not be office. RN-A stated, "I have office. RN-A stated, "I have office. RN-A stated [RN-D] was d not do those skills and left nplete. RN-A stated [RN-D] g comfortable completing those independently. RN-A				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND F LAIN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00149	B. WING		C 01/30/2020	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE ZIP CODE		
		1412 WF	ST FOURTH S			
AY VIE	W NURSING & REHA	BILITATION CENT	NG, MN 55066			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 300	Continued From pa	age 9	2 300			
	pool staff agency owner provided RN-D's phone number and stated, "We don't do vent/trach training. The facility does that training." The owner further stated the agency would send the facility a self evaluation competency checklist upon hire.					
	confirmed not havi at the facility. RN-E of orientation prior shift with LPN-C, b how to suction or c	on 1/30/20, at 1:20 p.m. RN-D ng specific vent/trach training 0 confirmed having four hours to the start of first scheduled ut the training did not include are for vents/tracheostomy's. rmed there was no checklist to encies.				
	indicated, "Suction every shift for exce distress to maintain number of times su	Iministration record (TAR) ing: May suction as needed essive secretions/respiratory n airway; Document total uctioned each shift." R41's TAF ctioned R41 once during the 20.	2			
	and Suction Comp checklist with spec checked off by a n	y Trach Stoma Care, Cleaning etency identified a competency ific steps to be observed and urse. RN-D's competency ested but not provided.				
	(Endotracheal or T identified the proce in order to maintain infection. The poli supplies, what to a procedure for suct	Suctioning Lower Airway rach Tube) revised 3/14, edure for removing secretions in an open airway and prevent cy indicated the necessary ssess, and step by step ioning. The policy identified a sterile procedure. The policy	/			

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED	
		00149	B. WING			C 01/30/2020	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AY VIEV	W NURSING & REHA	BILITATION CENT	ST FOURTH S				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 300	Continued From pa	age 10	2 300				
	infection, and hypo done correctly.	xia if the procedure was not					
	revised 10/17, indic employed or contra facility-specific, cor development and to further indicated lic demonstrate specific deemed necessary residents. The polic competency based	Competency of Nursing Staff cated all licensed nursing staff acted will participate in a npetency-based staff raining program. The policy ensed nurses would fic competencies and skill sets to care for the needs of cy further indicated the staff training program would skills needed based on the t.					
	administrator or de and implement poli tracheostomy and provide training to t nurses, along with in this area. The qu assurance committ audits to ensure co						
	TIME PERIOD FO (21) days	R CORRECTION: Twenty One					
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			3/17/20	
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.					
	This MN Requirem	ent is not met as evidenced					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED
		00149	B. WING	B. WING		C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH IG, MN 5506			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	ge 11	21375			
B re fc (I p	by: Based on observation, interview and document review, the facility failed to properly identify and follow contact precautions for 1 of 1 residents (R13) reviewed for transmission based precautions.			Corrected		
	Findings include:					
	R13's significant change Minimum Data Set (MDS) dated, 10/25/19, identified R13 as cognitively intact and required set up assist or assist of one for many activities of daily living (ADLs). R13's MDS further identified diagnoses osteomyelitis (infection in the bones), sepsis (infection in the blood), multiple pressure ulcers, enterocolitis due to clostridium difficile (C. diff is a a bacterium that can cause symptoms such as diarrhea of the colon), neurogenic bladder (a condition in which the bladder does not empty urine properly due to nerve damage), and paraplegia (impaired motor and sensory function of the lower extremities).					
	identified contact is resistant organism or other microorgar antibiotics). Contact for staff and visitors	ary report dated 12/19/19 olation due to multiple drug (MDRO occurs when bacteria hisms become resistant to t isolation identifies a process to glove and gown in order to and other residents.				
	personal protective floor outside and to was no sign on R13 precautions. After	on 1/27/20, at 1:08 p.m. equipment (PPE) was on the the left of R13's door. There 3's door identifying knocking and asking r, R13 stated, "You better gown				

	IT OF DEFICIENCIES OF CORRECTION	Iealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			C
		00149	B. WING			30/2020
AME OF F	PROVIDER OR SUPPLIEF	R STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
	W NURSING & REHA	ARII ITATION CENT	ST FOURTH S NG, MN 55066			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLE DATE
21375	Continued From p	age 12	21375			
		on 1/27/20, at 1:21 p.m. (NA)-D stated R13 was not on				
		on 1/27/20, at 1:22 p.m. urse (LPN)-E stated R13 was tions for C diff.				
	supplies outside a	n on 1/28/20, at 11:13 a.m. PPE nd to the left of R13's door. No nat indicated contact				
	remained outside	n on 1/29/20, at 8:00 a.m. PPE and to the left of R13's door cautions sign was now s door.				
	LPN-C opened R1 entered room with was not wearing g beverages down of then gloved one h	n on 1/29/20, 11:14 a.m. I3's door with foot and then beverages in hands. LPN-C own or gloves. LPN-C set on the bed side table. LPN-C and and pulled door closed with hand hygiene was performed ter this.	ı			
	trained medication room and dropped TMA-A did not glo alcohol based han	n on 1/29/20, at 11:29 a.m. n assistant (TMA)-A entered d off cereal, bowl and milk. ve or gown. TMA-A used d rub (ABHR) prior to leaving oor closed with ungloved and				
	LPN-C entered R1 LPN-C did not app needed urinal emp	n on 1/29/20, at 12:48 p.m. I3's room to answer call light. bly gloves or gown. R13 stated otied. LPN-C stated, "Ok, let at." LPN-C stepped out of				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
					с	
		00149	B. WING		01/3	30/2020
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH S IG, MN 55066	TREET		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
21375	Continued From pa	age 13	21375			
	R13's room and applied gloves, gown and mask. After emptying urinal, LPN-C removed PPE and used ABHR. LPN-C pulled door shut with un-gloved and sanitized hand. When interviewed on 1/30/20, at 7:36 a.m. LPN-C stated, "If we are just standing in the room asking a question or dropping something off we do not have to gown." LPN-C further stated that R13's infection is in the wounds. "So unless we are doing wound cares we don't have to gown." LPN-C further stated, "It's sort of a gray area. If we are in there [R13's room] and [R13] requests we do something, we come back out and gown up. But if we just enter to drop off Styrofoam drinks, we do not have to gown." LPN-C further stated, "[R13] empties own colostomy [colon is redirected to an opening on abdomen and collected in a bag] and the Foley [urinary catheter] into the urinal and then we empty the urinal. That is when I would gown. I usually glove or use my foot to open the door as I don't know what is on the handle."					
	director of nursing necessary to gown on contact precauti linens or perform c when working direct should gown and g hope there is not a	on 1/30/20, at 7:58 a.m. (DON) stated it was not and glove when someone is ions and staff do not touch the ares. DON further stated ctly with the wound, staff love. DON further stated, "I sign on the door, [stating s]. It should just say check with dignity and such."				
	infection control nu should be a sign or of precaution and v	on 1/30/20, at 8:23 a.m. rse RN-A stated, "There n the door to say what the type vhat PPE was needed. You intact precautions room withou				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00149	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH S G, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa gowning even if jus Regardless of what staff were trained a precautions.	- t dropping something off. t infection." RN-A further stated	21375			
	Precautions dated precautions were to known or suspected transmitted by direct indirect contact with resident care items and visitors to wear The policy further in wear a disposable of and to remove gow room. The policy fur	nfection Control Isolation 10/18, indicated contact b be in place for residents with d infections that could be ct contact with resident or n environmental surfaces or . The policy instructed staff r gloves when entering room. Instructed staff and visitors to gown upon entering the room in and gloves prior to leaving irther instructed staff to ene after removing gloves room.				
	DON (Director of N review/revise facilit perform audits to e TIME PERIOD FOR	THOD OF CORRECTION: The ursing) or designee could y policies, educate staff and nsure compliance. R CORRECTION: Twenty-one				
21426	(21) days. MN St. Statute 144 Prevention And Con	A.04 Subd. 3 Tuberculosis ntrol	21426			3/17/20
	maintain a compret infection control pro current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease htion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR).				

	i <u>ta Department of He</u> IT OF DEFICIENCIES	aith (X1) provider/supplier/clia	(X2) MULTIP	LE CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		:		PLETED
		00149	B. WING		C 01/30/2020	
						00/2020
NAME OF F	PROVIDER OR SUPPLIER		ST FOURTH	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA		IG, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21426	Continued From no	ao 15	21426	DEFICIENCY		
21420	Continued From pa	0	21420			
	infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	include a tuberculosis in that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must ne nursing home.				
	by: Based on document facility failed to ens screens were comp	ent is not met as evidenced at review and interview, the ure tuberculosis (TB) symptom pleted within 72 hours of of 5 residents (R30 and TB screening.	h	Corrected		
	Findings include:					
	date of 8/26/19. Sta tuberculin skin test	ecord form showed an admit aff administered the first on 8/26/19, but did not provide eting a TB history or symptom ours of admission.	\$			
	date of 1/14/20. Sta tuberculin skin test evidence of comple	Record form showed an admit aff administered the first on 1/14/20, but did not provide eting a TB history of symptom rst 72 hours of admission.				
uposata Di	(RN)-A confirmed b	2 p.m. registered nurse eing unable to find TB history or symptom				
TE FOR			6899	RPBE11	lf continuati	on sheet 16

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED C 30/2020
		00149		01,		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST ST FOURTH S			
BAY VIE	W NURSING & REHA	BILITATION CENT	IG, MN 55066	IREEI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	ge 16	21426			
	screen for R30 or F	R234.				
	Program, revised J identification and m is essential." The p timeline in which th	Prevention and Control anuary 2020, included, "Early nanagement of person with TB olicy did not specify the e TB history and symptom be completed for a newly				
	director of nursing (review and/or revise procedures to ensu for physical signs a disease on admissi could educate the a policies/procedures	THOD OF CORRECTION: The (DON) or designee could e the current TB policies and irre all residents are screened nd symptoms of active TB ion. The DON or designee appropriate staff on the s, and could develop a by auditing residents' charts to mpliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
21530	MN Rule 4658.1310	0 A.B.C Drug Regimen Review	21530			3/17/20
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finance This standard is in available through th system. It is not su	en of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ibject to frequent change. hoist must report any				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		00149	B. WING			C 30/2020
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	W NURSING & REHA	BILITATION CENT	ST FOURTH			
(X4) ID	SUMMARY STA		NG, MN 5506	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLE DATE
21530	Continued From pa	age 17	21530			
	and the attending p must be acted upon physician visit, or se pharmacist. For pu- upon" means the a report and the sign of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to the if the medical direct physician. If the me the attending physic justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical director must refer the matter	director of nursing services obysician, and these reports in by the time of the next ooner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ling physician does not concur t's recommendation, or does ate justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist cer directly to the quality ssurance committee.	3			
	by: Based on documer facility failed to add recommendations f	ent is not met as evidenced nt review and interview, the lress pharmacy for 1 of 5 residents (R30) ressary medications.		Corrected		
		imum Data Set (MDS) 19, described R30 to have a mood disorder, mental				

STATE FORM

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	OF CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:	······	COM	
		00149	B. WING			C 30/2020
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1412 WE	ST FOURTH S	TREET		
SAY VIE	W NURSING & REHA	BILITATION CENT RED WIN	IG, MN 55066			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO 1	THE APPROPRIATE	DATE
				DEFICIENC	Y)	
21530	Continued From pa	age 18	21530			
	without loss of con	sciousness. R30 was taking				
		a routine basis, and received ar				
		cation seven out of seven days				
		ck period, with no gradual dose npted since admit 8/26/19.				
	reduction yet atten					
		der dated 11/2/19, for 12.5				
		quetiapine fumarate, an				
		cation, was scheduled at				
	bedume for unspec	cified mood affective disorder.				
	R30's Consultant F	Pharmacist's Medication				
		0/19, recommended the				
		s for antipsychotic monitoring				
		becific target behaviors, side tatic blood pressures." R30's				
		vide evidence that the facility				
		0 for side effects related to				
	antipsychotic medi	cation use, or target behaviors				
	R30's sleep care p	lan initiated 11/13/19, noted				
	R30's inability to sl	eep well due to anxiety. One of	F			
		as to give R30 quetiapine per				
		where else on the care plan did				
		the antipsychotic medication, ide effects and target				
	behaviors.	ao onoolo ana largot				
	When interviewed	$an \frac{1}{20}$				
		on 1/29/19, at 2:03 p.m. hurse (LPN)-A stated that side				
		ehavior monitoring should be in	n			
	the treatment adm	inistration record (TAR), as the				
		ch for side effects and target				
		ents taking antipsychotic				
		their shift, and document if erns on the TAR. LPN-A				
		ders and did not find an order				
	for side effect or ta	rget behavior monitoring.				
		provide evidence of side				
	effect/target behav	vior monitoring.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00149	B. WING			C 30/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH S NG, MN 55066			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21530	Continued From pa	age 19	21530			
	When interviewed on 1/30/20, at 9:15 a.m. Pharmacist (Ph)-E stated he recommended in December 2019, the facility should add an order to monitor R30 for side effects and target behaviors related to the antipsychotic medication, and noted the facility did not implement this recommendation until 1/29/20. Ph-E's monthly visits to the facility included looking for appropriate side effect and target behavior monitoring.		,			
	11/27/19, included pharmacist had rev regimen, and made needed to be revie recommendations	tes dated 8/31/19, and notes that a different viewed R30's medication e recommendations that wed. The pharmacist's could not be located in the record. The recommendations t not provided.				
	revised April 2014, review each reside least monthly, and actual problems de and recommendati	acy Services procedure required the pharmacist to nt's medication regimen at to communicate potential or etected and document findings ons. This policy did not specify ould respond to and maintain				
	Assessment and R 2017, required all r	gical medication to be				
	director of nursing review and revise p	THOD OF CORRECTION: The (DON) or designee could policies and procedures for and irregularities including				

ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		00149	B. WING			C 30/2020
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
AY VIE	W NURSING & REHA		ST FOURTH S IG, MN 55066			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21530	to check side effect nursing or designed educate staff and d ensure pharmacy r are being acted up are regularly being assurance committ measures to ensur	nedication monitoring systems t monitoring. The director of e could develop a system to levelop a monitoring system to eviews are timely, irregularities on and potential side effects monitored. The quality tee could monitor these				
21540	MN Rule 4658.131 Usage; Monitoring Subp. 2. Monitoring monitor each reside unnecessary drug of home's policies and pharmacist must re- resident's attending physician does not home's recommen- adequate justification believes the reside adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, to review to the Qualiti (QAA) committee r	5 Subp. 2 Unnecessary Drug g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If or determines that the attending have adequate justification for e attending physician does not the matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director,	9			3/17/20

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00149	B. WING			C 30/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
21540	Continued From pa	ige 21	21540			
	by: Based on interview facility failed to mor for 1 of 2 residents an anticoagulant (b addition, the facility taking psychotropic			Corrected		
	Findings include:					
	(MDS) dated 10/25 cognitively intact ar assist of one for ma (ADLs). R13's MD3 of deep vein throm peripheral vascular to extremities). The	hange Minimum Data Set /19, identified R13 as nd required set up assist or any activities of daily living S further identified diagnoses bosis (blood clot), and disease (impaired blood flow e MDS further indicated R13 agulant seven of the seven sessment.				
	R13's anticoagulan	ted 11/7/19, failed to address t administration and did not hitor for side effects of this				
		on 1/27/20, at 1:18 p.m. R13 Ig a blood thinner daily and, "I ne two weeks ago."				
	licensed practical n resident is on a blo bruising, and monit	on 1/27/20, at 1:18 p.m. Jurse (LPN)-C stated when a od thinner, "We look for or other things. Can I look in administration record]?"				

ND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		_DING:		PLETED	
		00149	B. WING			C 30/2020
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH S IG, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
IAO			IAG	DEFICIEN		
21540	Continued From pa	ge 22	21540			
	LPN-C opened a di	fferent resident's electronic				
		R) and confirmed residents on	1			
		e monitored for the following:				
		lack tarry stools, sudden				
		N&V [nausea and vomiting],				
		int pain, lethargy [lack of asm], bruising, sudden				
		status and/or V/S [vital signs],				
		breath], nose bleeds." LPN-C				
		urses monitor for side effects				
		s including Eliquis and Xarelto.				
		y the LPNs mark those [on the	•			
	TAR], TMAs [traine	d medication aide] do not."				
	M/hon interviewed					
		on 1/30/20, at 8:02 a.m. nticoagulant side effects				
		d every shift and documented				
		ered nurse (RN)-B stated, "It				
		ders [to monitor the side				
	effects]." RN-B acc	essed R13's eMR and				
		taking Xarelto. RN-B further				
	,	"It would have to be in here				
		checking for side effects.				
		n [R13's] chart." RN-B further not be a direct order from the				
		is a template that the facility				
		ursing (DON) verified and				
		ould check side effects when a				
		nticoagulant." DON further				
		r monitoring side effects was				
	••	ected when the order for the				
	anticoagulant was e	entered into the eMR.				
	When interviewed	on 1/30/20, at 9:16 a.m.				
		ed side effects should be				
	•	dents taking Xarelto.				
		confirmed the protocol for				
		effect monitoring should be				
	entered into the eM					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00149	B. WING			C 30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
BAY VIE	W NURSING & REHAI	BILITATION CENT	ST FOURTH ST IG, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21540	R13's order summa included an order for date of 12/19/19 for foreign object, or ot becomes stuck in a of left popliteal (back knee joint) vein. R1 failed to include the effects of the antico R13's TAR for Dece failed to include more anticoagulant. The facility policy A Low Molecular Wei revised 11/14 identif monitor for complic therapy. The policy side effects such as urine), hemoptysis other evidence of b R30's quarterly Min assessment 11/25/ diagnoses including disorder, and traum without loss of cons antipsychotic medic days during the lool reduction yet attem R30's physician ord milligrams (mg) of c antipsychotic medic	ary report as of 1/30/20, br 20 mg Xarelto with an order r acute embolism (a blood clot, ther bodily substance that a blood vessel) and thrombosis ck part of the leg behind the 3's order summary report e order for monitoring side bagulant. ember 2019 and January 2020 onitoring for side effects of an nticoagulation with Warfarin, ght Heparin, or Lovenox ified process for staff to ations of anticoagulation / instructed staff to monitor for s hematuria (blood in the (coughing up blood), and any leeding. imum Data Set (MDS) 19, described R30 to have g mood disorder, mental natic subdural hemorrhage sciousness. R30 was taking routine basis, and received cations seven out of seven k back, with no gradual dose pted since admit 8/26/19. der dated 11/2/19, for 12.5 quetiapine fumarate, an cation, was to be given at R30's diagnosis of unspecified				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM	PLETED
		00149	B. WING			C 30/2020
	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		1412 WE	ST FOURTH S	TREET		
BAY VIE	W NURSING & REHA	BILITATION CENT RED WIN	IG, MN 55066			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLET DATE
		,		DEFICIENC	CY)	
21540	Continued From pa	age 24	21540			
	R30's Consultant F	Pharmacist's Medication				
		0/19, recommended the facility	,			
		ipsychotic monitoring including				
		get behaviors, side effects, and				
		ressures." R30's orders did not				
		nat the facility was monitoring				
		s related to antipsychotic				
	medication use, or	target benaviors.				
	R30's sleen care n	lan initiated 11/13/19, noted				
		eep well due to anxiety. One of	:			
		as to give R30 quetiapine per				
		here else on the care plan did				
		the antipsychotic medication,				
	or monitoring for si	de effects and target				
	behaviors.					
	When interviewed	on 1/29/19, at 2:03 p.m.				
		nurse (LPN)-A stated side				
		ehavior monitoring should be in	1			
	the treatment admi	nistration record (TAR), as the				
		h for side effects and target				
		nts taking antipsychotic				
		their shift, and document if				
		erns on the TAR. LPN-A lers and did not find an order				
		rget behavior monitoring.				
		provide evidence of side				
	effect/target behav	•				
	When interviewed	on 1/30/20, at 9:15 a.m.				
		stated he recommended in				
		ne facility should add an order				
		side effects and target				
		o the antipsychotic medication,				
	and noted the facili	ty did not implement this				
		ntil 1/29/20. Ph-E's monthly				
		included looking for				
		fect and target behavior				
	monitoring.					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00149	B. WING		01/	30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH S NG, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	ge 25	21540			
	included moderate diagnoses including and post traumatic an antipsychotic me during the look bac reduction attempted ambulate during the but needed extensi transfer. R77's Adm diagnoses of repea	S assessment dated 1/7/20, cognitive impairment with g non-Alzheimer's dementia, stress disorder. R77 received edication 7 out of 7 days k period, with a gradual dose d 2/19/19. R77 did not e seven day look back period, ve assist of two staff to hission Record form included ted falls, and recurrent severe isorder without psychotic				
	antipsychotic medic fumarate), at 300 m related to post traus also had orders for blood pressures (bl performed in succe then standing) mon month. Orthostatic	der dated 7/5/19, for cation Seroquel (quetiapine ng each night before bed matic stress disorder. R77 staff to check orthostatic ood pressure checks sion while laying, then sitting thly on the 15th of every blood pressure measures for sure as a person moves from ng, to standing.	,			
	Drug Administration side effect of taking pressure (orthostat lightheadedness or change in heart rate	cation Guide on the Food and n website notes one possible g Seroquel is decreased blood ic hypotension), "including fainting caused by a sudden e and blood pressure when om a sitting or lying position."				
	described R77 to n in and out of bed, to toilet. The care plar	bility care plan initiated 8/7/18, eed supervision with transfers o the wheelchair, and to the n noted R77 often did not wait ot ask for staff assist and				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00149	B. WING			C 30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BAY VIE	W NURSING & REHA	RILITATION CENT	ST FOURTH S IG, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	ige 26	21540			
	had falls related to described R77 to b medications, such a negative side effect example monthly o R77's TAR included monthly orthostatic measurements on t did not document o the TAR in January and Vitals Summar orthostatic blood pr Interview on 1/30/2 explained his month residents for side e confirmed orthostatic part of side effect n	The care plan also noted R77 unsteady gait. The care plan e taking psychotropic as Seroquel, and to monitor for ts of the medication, for rthostatic blood pressure. d a place for staff to document blood pressure the 15th of every month. Staff orthostatic blood pressure on 2020. Review of the Weights y showed the last documented ressure check on 12/15/19. 0, at 9:15 a.m. Pharmacist-E hly visits included reviewing ffect monitoring, and tic blood pressure checks were nonitoring for residents taking cations who may be	r			
	2017, required all re	eview plan revised November esidents on a gical medication to be				
	administrator, direct consulting pharmace policies and procect medication usage. with the pharmacist	THOD OF CORRECTION: The stor of nursing (DON) and cist could review and revise lures for proper monitoring of The DON or designee, along t, could audit medication ar basis to ensure compliance.				
	TIMEFRAME FOR (21) days.	CORRECTION: Twenty-one				