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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RPBE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245223**
2.STATE VENDOR OR MEDICAID NO.
(L2) **955270700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAY VIEW NURSING & REHABILITATION CENTER**
(L4) **1412 WEST FOURTH STREET**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2019**

6. DATE OF SURVEY **3/31/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **110** (L18)
13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
x Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 4/15/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 4/15/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RPBE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245223**
2.STATE VENDOR OR MEDICAID NO.
(L2) **955270700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAY VIEW NURSING & REHABILITATION CENTER**
(L4) **1412 WEST FOURTH STREET**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2019**

6. DATE OF SURVEY **01/30/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **110** (L18)
13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 02/24/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 03/02/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

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.

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:

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on January 27 through January 30, 2020, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency	E 026	The plan and response to CMS 2567 is written solely to maintain certification in	3/17/20

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

Electronically Signed | 02/19/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 1 preparedness policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, (a waiver designed to waive specific regulatory requirements in order to more easily provide needed care in an emergency situation) in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 90 residents, staff and visitors at the facility. Findings include: The facility policy and procedures for emergency preparedness, revised April 2019, failed to address the role of the facility under a 1135 waiver by declared by the Secretary. When interviewed on 1/30/20, at 12:23 p.m. safety and security director (SSD)-A verified the facility emergency preparedness plan and procedures did not address operation under a 1135 waiver.	E 026	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	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local	E 032		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 032	Continued From page 2 emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the emergency preparedness communication plan included primary and alternate means for communicating with staff and Federal, State, tribal, regional, and local emergency management agencies. This had the potential to affect all patients 90 residents in the facility. Findings include: The facility Emergency Preparedness Plan and Procedure, revised April 2019, did not include a communication plan that included alternative means of communication with Federal, State, tribal, regional, and local emergency management agencies. A staff communication contact list and procedure was requested but not submitted. When interviewed on 1/30/20, at 12:23 p.m. safety and security director (SSD)-A verified the plan and procedure did not include alternate means of communication with staff, clients, Federal, State, tribal, regional, and local emergency management agencies.	E 032	**The Emergency Communication Preparedness Plan has been developed and complies with Federal State and Local Laws. **The Emergency Preparedness Plan has been revised to include a communication plan including primary and alternate means for communicating with the following: facility staff, federal, state, tribal, regional, and local emergency management agencies. Person Responsible: Maintenance Director	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1)	E 037		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 3 *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 4 others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 5 (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 6 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to train new and current staff, individuals providing services under arrangement, and volunteers regarding their policy and procedures for the facility emergency preparedness plan (EPP). This had the potential to affect all 90 residents in the facility, as well as staff and visitors. Findings include: The facilities emergency plan, updated in April 2019, identified, "Staff members are trained on the facility's emergency plans, policies, and procedures upon hire and at a minimum semi-annually." When requested, the facility failed	E 037	** Emergency Preparedness Policy and Procedure have been reviewed and revised to all new and existing employees, contracted employees. **New Employee Orientation Emergency Preparedness will be topic on the agenda. ** New Department communication book at each unit will contain tab for Emergency Preparedness fact sheet. **Audit Orientation records for compliance every month. Initially audit all employee records for attendance at Emergency preparedness Training. **Person Responsible: Maintenance Director & Staff Development Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 7 to provide documentation of initial and annual training that demonstrated knowledge of the emergency plan and procedures for all new and existing staff, as well as individuals providing services under arrangement and volunteers. During interview on 1/29/30, at 6:59 a.m. registered nurse (RN)-G stated they had not received facility specific training that demonstrated knowledge of the facilty emergency preparedness policies and procedures. During interview on 1/29/30, at 7:43 a.m. nursing assistant (NA)-E stated they had not received facility specific training that demonstrated knowledge of the facilty emergency preparedness policies and procedures. During interview on 1/29/30, at 8:30 a.m. NA-F stated they had not received facility specific training that demonstrated knowledge of the facilty emergency preparedness policies and procedures. During interview on 1/29/30, at 8:47 a.m. speech and language pathologist (SLP)-A stated they had not received facility specific training that demonstrated knowledge of the facilty emergency preparedness policies and procedures. During interview on 1/30/20, at 12:23 p.m. safety and security director (SSD)-A verified the facility had not conducted documented emergency preparedness training for staff on orientation or annually that demonstrated staff knowledge of the facility's emergency preparedness plan and procedures.	E 037		
E 039	EP Testing Requirements	E 039		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039 SS=C	Continued From page 8 CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 9 emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 10 emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 11 §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):]	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 12 (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]:	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 13 (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 14 or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 emergency preparedness exercises, including both a community based, full scale exercise and another full scale community based exercise or a table top exercise were completed annually to test their emergency preparedness plan. This had the potential to affect all 90 residents currently in the facility. Findings include: The facilities emergency preparedness plan, updated April 2019, identified the following; "In addition to the establishment of a regular training program, Bay View Nursing and Rehabilitation Center shall conduct training exercises, drill and simulations at least semi-annually and in accordance with all applicable local, state and federal guidelines. [CMS Proposed Guidelines.]" The facility provided no evidence that a full scale, community based exercise or a table top exercise	E 039	**The Safety Committee will meet on 2-27-2020 and determine the date for a table top exercise. ** The Maintenance Director will also contact the County Emergency Management Director to discuss the county wide exercise for this year. After completion of a Community based exercise, an after action review will be completed to identify deficiencies in our plan. Person Responsible: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 15 had been conducted in the last year when this was requested. Having not participated in a full scale community based exercise, the facility did not provide evidence documenting that they had attempted to participate in a full scale community based exercise. When interviewed on 1/30/20, at 12:23 p.m. safety and security director (SSD)-A verified the facility had not conducted documented emergency preparedness exercises in the last year.	E 039		
F 000	INITIAL COMMENTS Bay View Nursing and Rehabilitation Center is a Special Focus Facility (SFF) and received a recertification survey on 1/27/20 through 1/30/20. Complaint investigations were also conducted. Your facility was found not to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5223177C. No deficiency issued. H5223179C. No deficiency issued. The following complaints were found unsubstantiated: H5223170C. H5223171C. H5223172C. H5223173C. H5223174C. H5223175C. H5223176C.	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 16 H5223178C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure pool (temporary agency)staff were trained and competent to provide tracheostomy (tube inserted through an opening in the neck into the windpipe) care and suctioning for 1 of 3 residents (R41) reviewed for mechanical ventilation/tracheostomy. Findings include:	F 695	F695 **R41 Depth of suctioning will be re-evaluated by Northwest Respiratory and scale kept at bed side. R41 Care plan has been updated to reflect the change. **All facility residents who require regular or routine suctioning will also be re-evaluated by Northwest Respiratory for depth of suctioning and scale kept at bedside.	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 17 R41's quarterly Minimum Data Set (MDS) dated 12/9/19, identified R41 was cognitively intact and required extensive physical assistance with support of two plus persons for most activities of daily living (ADLs). The MDS further identified R41's diagnoses of acute respiratory failure with hypoxia (decreased level of oxygen available for body tissues), morbid obesity, and tracheostomy (trach) status. R41's care plan (CP) last reviewed 1/18/20, indicated R41 was ventilator (vent) dependent related to impaired breathing mechanics at night. The CP instructed staff to assess for signs and symptoms of hypoxia. The CP further indicated the ventilator settings and nebulizer treatments via the trach. When interviewed on 01/27/20, at 2:37 p.m. R41 stated pool staff do not perform proper trach care. R41 stated one pool nurse, licensed practical nurse (LPN)-F made (R41) bleed, "not too long ago" during suctioning. During observation on 1/29/20, at 8:11 a.m. LPN-C entered R41's room to remove from vent and provide trach suctioning. LPN-C applied gloves, vent was disconnected, and humidified oxygen placed to trach via trach dome. LPN-C retrieved a suction kit, removed gloves, and used alcohol based hand rub (ABHR). Sterile gloves applied from suction kit. Balloon deflated and trach suctioned three times. Balloon inflated. LPN-C then used a Yankauer (suction tip) to suction mouth. LPN-C removed gloves and washed hands. When interviewed on 1/29/20, at 9:02 a.m. R41 stated, "I think it was a pool nurse, did not deflate	F 695	**The process of how this facility trains licensed staff was reviewed and updated to include new competency training. **All licensed staff who work with tracheostomy residents receive education prior to providing Tracheostomy Care, & Vent Care. **Residents with Trach's, those requiring suctioning . *Both Licensed Nurses from the Agency received additional training on Trach Care Suctioning and Vent Care on 1-30 -2020* Northwest Respiratory(NWR) to complete education/training to staff regarding tracheostomy care, suctioning & Vent Care. Initiated 2-20-2020 *Competency check list to be completed by staff development RN/RN Manager with each new staff or pool staff prior to working with any resident requiring tracheostomy/care suctioning **Education will be provided for Pool staff and new licensed staff hired prior to working with tracheostomy residents. **Competency checks completed for all current pool staff to ensure compliance of facility policy and procedure. **Audit will be completed weekly after initial training by (NWR) and Bay View Orientation, times 1 training and 3 orientations, until 100% compliance as determined by QAPI Committee. ** Person responsible: Infection control/Staff development RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 18	F 695		

the cuff prior to suctioning." R41 further stated, "I needed suctioning and [registered nurse (RN)-D] did not deflate the balloon and did not get anything out with the suction." R41 stated, "When I told [RN-D], he told me I am supposed to remind him. I told [RN-D] you are supposed to know that."

R41's progress note by RN-D dated 1/29/20, at 3:08 a.m. indicated R41 requested suctioning at 1:00 a.m. Progress note included, RN-D deflated balloon before suctioning resident and inflated balloon prior to leaving R41's room. The progress note further indicated RN-D checked on R41 at 3:00 a.m. when R41 told RN-D that RN-D did not deflate the balloon before suctioning last time.

When interviewed on 1/29/20, at 01:14 p.m. LPN-C stated, "You don't always have to deflate the cuff prior to suctioning but with [R41] you do. [R41] has granulomas [growth] forming and if you do not deflate the cuff first you can either not pass by them or nick them and cause bleeding."

When interviewed on 1/30/20, at 7:43 a.m. director of nursing (DON) stated the facility recently experienced some staff turnover. DON stated the previous nurse manager provided most of the vent/trach training to staff. A respiratory therapist from the facility's contracted respiratory vendor also supplied some training to staff. DON stated RN-A was the new trainer and would be able to provide more information about training. Pool staff would work with regular staff nurses like LPN-C. DON stated, "We would not put anyone down there without experience or alone. [LPN-F] is a pool nurse and has been doing great down there working with [LPN-C]. I think [RN-D] is pool staff." RN-B was also in the office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 19	F 695		

and confirmed RN-D was a pool RN. LPN-D also in the office confirmed the previous nurse manager did most of the vent training. LPN-D stated, "pool staff get training from regular staff prior to working their first shift. DON confirmed and stated, RN-A used to be a nurse on the floor at the facility and was now the staff trainer and infection control nurse. DON further stated, "[RN-A] is developing a training program. The competency check off is pretty weak. We had to scrape from the previous person. We had a check off list and it was not accurate. We have to change this."

When interviewed on 1/30/20, at 8:30 a.m. RN-A stated, "Packets for pool are supposed to be done before the first shift. They come in early. I would be responsible to check them off." RN-A confirmed pool staff were "checked off just prior to their first shift from whatever staff is here." RN-D's competency checklist could not be located in RN-A's office. RN-A stated, "I have worked with [RN-D] here before." RN-A further stated RN-D did not perform vent/trach cares on that shift. RN-A stated, "[RN-D] has been here a month or two and I know that when [RN-D] was working with me did not do those skills and left them for me to complete. RN-A stated [RN-D] reported not feeling comfortable completing those cares (vent/trach) independently. RN-A confirmed the facility cannot produce any documentation that RN-D received vent/trach training or that RN-D was competent from previous training.

When interviewed on 1/30/20, at 11:05 a.m. the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 20	F 695		

owner further stated the agency would send the facility a self evaluation competency checklist upon hire.

When interviewed on 1/30/20, at 1:20 p.m. RN-D confirmed not having specific vent/trach training at the facility. RN-D confirmed having four hours of orientation prior to the start of first scheduled shift with LPN-C, but the training did not include how to suction or care for vents/tracheostomy's. RN-D further confirmed there was no checklist to sign off for competencies.

R41's treatment administration record (TAR) indicated, "Suctioning: May suction as needed every shift for excessive secretions/respiratory distress to maintain airway; Document total number of times suctioned each shift." R41's TAR indicated RN-D suctioned R41 once during the night shift on 1/29/20.

The undated facility Trach Stoma Care, Cleaning and Suction Competency identified a competency checklist with specific steps to be observed and checked off by a nurse. RN-D's competency checklist was requested but not provided.

The facility policy Suctioning Lower Airway (Endotracheal or Trach Tube) revised 3/14, identified the procedure for removing secretions in order to maintain an open airway and prevent infection. The policy indicated the necessary supplies, what to assess, and step by step procedure for suctioning. The policy identified trach suctioning is a sterile procedure. The policy also indicated that there are possible complications such as trauma to the airway, infection, and hypoxia if the procedure was not done correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 21 The facility policy Competency of Nursing Staff revised 10/17, indicated all licensed nursing staff employed or contracted will participate in a facility-specific, competency-based staff development and training program. The policy further indicated licensed nurses would demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents. The policy further indicated the competency based staff training program would contain specialized skills needed based on the resident population.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 22 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to address pharmacy recommendations for 1 of 5 residents (R30) reviewed for unnecessary medications. Findings include: R30's quarterly Minimum Data Set (MDS) assessment 11/25/19, described R30 to have diagnoses including mood disorder, mental disorder, and traumatic subdural hemorrhage without loss of consciousness. R30 was taking antipsychotics on a routine basis, and received an antipsychotic medication seven out of seven days during the look back period, with no gradual dose reduction yet attempted since admit 8/26/19. R30's physician order dated 11/2/19, for 12.5 milligrams (mg) of quetiapine fumarate, an antipsychotic medication, was scheduled at bedtime for unspecified mood affective disorder.	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 been reviewed and updated to include how the facility will respond to and follow up on recommendations. **RN Nurse Managers will identify other residents on Psychotropics and implement monitoring for orthostatic blood pressures, targeted behaviors and side effect monitoring. **Nurse managers to review all pharmacy recommendations and complete recommendations within consultants recommended time frame. **Audit will be completed monthly by DON	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 23 R30's Consultant Pharmacist's Medication Review dated 12/20/19, recommended the facility, "add orders for antipsychotic monitoring including patient specific target behaviors, side effects, and orthostatic blood pressures." R30's orders did not provide evidence that the facility was monitoring R30 for side effects related to antipsychotic medication use, or target behaviors. R30's sleep care plan initiated 11/13/19, noted R30's inability to sleep well due to anxiety. One of the interventions was to give R30 quetiapine per doctor orders. Nowhere else on the care plan did the facility address the antipsychotic medication, or monitoring for side effects and target behaviors. When interviewed on 1/29/19, at 2:03 p.m. licensed practical nurse (LPN)-A stated that side effect and target behavior monitoring should be in the treatment administration record (TAR), as the nurses had to watch for side effects and target behaviors in residents taking antipsychotic medications during their shift, and document if they saw any concerns on the TAR. LPN-A reviewed R30's orders and did not find an order for side effect or target behavior monitoring. R30's TAR did not provide evidence of side effect/target behavior monitoring. 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	F 756	or designee for Pharmacy Reviews responses & follow-up until 100% compliance completed is achieved as determined by the QAPI committee. ** Person responsible: DON or designee **Audits for residents being placed on Psychotropics or new admissions/re-admissions will be completed every 2 weeks x3 months or until 100% Compliance as determined by the QAPI Committee, ** Person responsible: Clinical Coordinators or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 24 monitoring. R30's progress notes dated 8/31/19, and 11/27/19, included notes that a different pharmacist had reviewed R30's medication regimen, and made recommendations that needed to be reviewed. The pharmacist's recommendations could not be located in the electronic medical record. The recommendations were requested but not provided. The current Pharmacy Services procedure revised April 2014, required the pharmacist to review each resident's medication regimen at least monthly, and to communicate potential or actual problems detected and document findings and recommendations. This policy did not specify how the facility should respond to and maintain recommendations. The Psychopharmacologic Medication Assessment and Review plan revised November 2017, required all residents on a psychopharmacological medication to be monitored for side effects.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 25 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor for potential side effects for 1 of 2 residents (R13) reviewed who received an anticoagulant (blood thinner) medication. 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 of deep vein thrombosis (blood clot), and peripheral vascular disease (impaired blood flow to extremities). The MDS further indicated R13 received an anticoagulant seven of the seven days prior to the assessment. R13's care plan dated 11/7/19, failed to address R13's anticoagulant administration and did not instruct staff to monitor for side effects of this medication. When interviewed on 1/27/20, at 1:18 p.m. R13 stated he was taking a blood thinner daily and, "I	F 757	F757 *R13 orders and Plan of Care updated to reflect Anticoagulation *monitoring. *All Inhouse residents on anticoagulant medication are in process reviewed with care plans updated, monitoring of side effects. *Nurse manager or designee to review new admission orders to assure proper monitoring of anticoagulant medications. *Education on anticoagulants, Side effects, & *Audit will be completed monthly until 100% compliance completed is achieved as determined by the QAPI committee. ** Person responsible: Unit Clinical Coordinator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 26 had blood in my urine two weeks ago." When interviewed on 1/27/20, at 1:18 p.m. licensed practical nurse (LPN)-C stated when a resident is on a blood thinner, "We look for bruising, and monitor other things. Can I look in the TAR [treatment administration record]?" LPN-C opened a different resident's electronic medical record (eMR) and confirmed residents on anticoagulants were monitored for the following: "discolored urine, black tarry stools, sudden severe headache, N&V [nausea and vomiting], diarrhea, muscle joint pain, lethargy [lack of energy and enthusiasm], bruising, sudden changes in mental status and/or V/S [vital signs], SOB [shortness of breath], nose bleeds." LPN-C further stated the nurses monitor for side effects of all anticoagulants including Eliquis and Xarelto. LPN-C stated, "Only the LPNs mark those [on the TAR], TMAs [trained medication aide] do not." When interviewed on 1/30/20, at 8:02 a.m. LPN-D confirmed anticoagulant side effects should be monitored every shift and documented on the TAR. Registered nurse (RN)-B stated, "It should be in the orders [to monitor the side effects]." RN-B accessed R13's eMR and confirmed R13 was taking Xarelto. RN-B further verified and stated, "It would have to be in here [the TAR] if we are checking for side effects. There is no order in [R13's] chart." RN-B further confirmed it would not be a direct order from the provider because it is a template that the facility used. Director of nursing (DON) verified and stated, "Nurses should check side effects when a resident is on an anticoagulant." DON further stated, the order for monitoring side effects was supposed to be selected when the order for the anticoagulant was entered into the eMR.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 27 When interviewed on 1/30/20, at 9:16 a.m. pharmacist confirmed side effects should be monitored with residents taking Xarelto. Pharmacist further confirmed the protocol for anticoagulant side effect monitoring should be entered into the eMR by the facility staff. R13's order summary report as of 1/30/20, included an order for 20 mg Xarelto with an order date of 12/19/19 for acute embolism (a blood clot, foreign object, or other bodily substance that becomes stuck in a blood vessel) and thrombosis of left popliteal (back part of the leg behind the knee joint) vein. R13's order summary report failed to include the order for monitoring side effects of the anticoagulant. R13's TAR for December 2019 and January 2020 failed to include monitoring for side effects of an anticoagulant. The facility policy Anticoagulation with Warfarin, Low Molecular Weight Heparin, or Lovenox revised 11/14 identified process for staff to monitor for complications of anticoagulation therapy. The policy instructed staff to monitor for side effects such as hematuria (blood in the urine), hemoptysis (coughing up blood), and any other evidence of bleeding.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 28 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 29 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents taking psychotropic medications were monitored for side effects and target behaviors for 2 of 5 residents (R30 and R77) reviewed for unnecessary medications. Findings include: R30's quarterly Minimum Data Set (MDS) assessment 11/25/19, described R30 to have diagnoses including mood disorder, mental disorder, and traumatic subdural hemorrhage without loss of consciousness. R30 was taking antipsychotics on a routine basis, and received antipsychotic medications seven out of seven days during the look back, with no gradual dose reduction yet attempted since admit 8/26/19. R30's physician order dated 11/2/19, for 12.5 milligrams (mg) of quetiapine fumarate, an antipsychotic medication, was to be given at bedtime related to R30's diagnosis of unspecified mood affective disorder. R30's Consultant Pharmacist's Medication Review dated 12/20/19, recommended the facility "add orders for antipsychotic monitoring including patient specific target behaviors, side effects, and orthostatic blood pressures." R30's orders did not provide evidence that the facility was monitoring R30 for side effects related to antipsychotic medication use, or target behaviors.	F 758	F758 *R30□S psychopharmacologic medications have been reviewed and corrections made to include side effect monitoring and target behaviors, also to include orthostatic blood pressure checks monthly. *All residents on psychopharmacologic medications will be reviewed and if indicated corrections made to include side effect monitoring and targeted behaviors, including orthostatic blood pressure checks monthly. *Nurse manager or designee to review new admission orders to assure proper monitoring of psychopharmacologic medications. *Audit will be completed monthly x2 moths or until 100% compliance is achieved as determined by the QAPI committee. *Person responsible: Unit Clinical Coordinator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 30	F 758		

R30's sleep care plan initiated 11/13/19, noted R30's inability to sleep well due to anxiety. One of the interventions was to give R30 quetiapine per doctor orders. Nowhere else on the care plan did the facility address the antipsychotic medication, or monitoring for side effects and target behaviors.

When interviewed on 1/29/19, at 2:03 p.m. licensed practical nurse (LPN)-A stated side effect and target behavior monitoring should be in the treatment administration record (TAR), as the nurses had to watch for side effects and target behaviors in residents taking antipsychotic medications during their shift, and document if they saw any concerns on the TAR. LPN-A reviewed R30's orders and did not find an order for side effect or target behavior monitoring. R30's TAR did not provide evidence of side effect/target behavior monitoring.

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.

R77's quarterly MDS assessment dated 1/7/20, included moderate cognitive impairment with diagnoses including non-Alzheimer's dementia, and post traumatic stress disorder. R77 received an antipsychotic medication 7 out of 7 days during the look back period, with a gradual dose reduction attempted 2/19/19. R77 did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 31	F 758		

ambulate during the seven day look back period, but needed extensive assist of two staff to transfer. R77's Admission Record form included diagnoses of repeated falls, and recurrent severe major depressive disorder without psychotic features.

R77's physician order dated 7/5/19, for antipsychotic medication Seroquel (quetiapine fumarate), at 300 mg each night before bed related to post traumatic stress disorder. R77 also had orders for staff to check orthostatic blood pressures (blood pressure checks performed in succession while laying, then sitting, then standing) monthly on the 15th of every month. Orthostatic blood pressure measures for drops in blood pressure as a person moves from laying down, to sitting, to standing.

The Seroquel Medication Guide on the Food and Drug Administration website notes one possible side effect of taking Seroquel is decreased blood pressure (orthostatic hypotension), "including lightheadedness or fainting caused by a sudden change in heart rate and blood pressure when rising too quickly from a sitting or lying position."

R77's transfers/mobility care plan initiated 8/7/18, described R77 to need supervision with transfers in and out of bed, to the wheelchair, and to the toilet. The care plan noted R77 often did not wait for staff or would not ask for staff assist and would self transfer. The care plan also noted R77 had falls related to unsteady gait. The care plan described R77 to be taking psychotropic medications, such as Seroquel, and to monitor for negative side effects of the medication, for example monthly orthostatic blood pressure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 32 R77's TAR included a place for staff to document monthly orthostatic blood pressure measurements on the 15th of every month. Staff did not document orthostatic blood pressure on the TAR in January 2020. Review of the Weights and Vitals Summary showed the last documented orthostatic blood pressure check on 12/15/19. Interview on 1/30/20, at 9:15 a.m. Pharmacist-E explained his monthly visits included reviewing residents for side effect monitoring, and confirmed orthostatic blood pressure checks were part of side effect monitoring for residents taking antipsychotic medications who may be ambulatory. The Psychopharmacologic Medication Assessment and Review plan revised November 2017, required all residents on a psychopharmacological medication to be monitored for side effects.	F 758		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS	F 836		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 33 Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to notify 43 of 88 current residents of a registered sex offender living in the facility. Findings include: R77's Admission Record form showed R77 admitted to the facility 8/3/18. R77's quarterly Minimum Data Set (MDS) assessment described R77 as having moderately 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.	F 836	F836 **R77 Care Plan updated to include not attending activities involving minor children nor will be offered 1 to 1 visits involving minors. Observe that he is not within reach of minor children and is close to nurses station and in a private room. R77 Plan of Care changes will be communicated to all facility staff involved in his care. **All residents admitted after the initial notification regarding Bay View admitting a sex offender will now receive a notification, as well as any future admissions. *Policy and Procedure developed and implemented for registered sex offender admitted and living in facility. □ *Sex Offender Notification forms and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 34 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 involved in sexual behaviors/aggression toward other residents. R77's medical record contained a Fact Sheet dated 8/3/18. The form was self titled as, "Information on a Registered Offender," and was "For Distribution to Facility Residents." Red Wing Police Department provided the Fact Sheet to the 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 R77 as risk level two, with conviction for criminal sex conduct (two counts) in 1993, of two female children known to R77. On 1/30/20, at 10:59 a.m. the director of social services (DSS) stated R77 had not wandered into any other resident rooms, touched people, or gotten close to anyone else. DSS stated the police department sent the Fact Sheet about R77's convictions after R77 was already admitted to the facility, and DSS personally distributed the notice to every resident and guardian at that time.	F 836	signature page given to current residents admitted since 8/7/18 and added to admission procedure for potential admissions ongoing. *Each signature page to be uploaded into resident□s electronic documentation record ** Social Services will be responsible for ensuring all residents are notified & documentation is present if sex offenders are admitted. **All residents since 8-18-19 will be audited to ensure they have been notified regarding sex offender in facility. **On going audits will be conducted, regarding notification of sex offenders in facility, every 2 weeks for new admissions unless otherwise determined by QAPI Committee. Person Responsible: Social Service Director or Designess	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 35	F 836		

DSS described having conversations with people to ensure they understood what the notice meant. Since 8/7/18, no new admissions had been notified of R77's convictions, because when staff searched for R77 on the online registry, R77's name did not come up. Registered nurse (RN)-E described searching for R77's name on an online registry at the time of receiving the Fact Sheet from the police, and being unable to find R77's name at that time. RN-E searched for R77's name multiple times on the online list, and never found it, so despite the Fact Sheet, RN-E was confused about whether R77 was truly a registered offender requiring notification to all the residents.

The current census list included 88 residents (including two residents currently in the hospital), and 43 of those residents were admitted after the initial notification took place on 8/7/18.

A facility policy on admitting registered offenders, and notifying residents of registered offenders was requested, but not provided. RN-E confirmed on 1/30/20, that the facility did not have such a policy.

The Minnesota (MN) Bureau of Criminal Apprehension Predatory Offender Registration website explained convictions of criminal sexual conduct required registration in MN. Additionally, risk level two indicated a moderate likelihood to re-offend. Furthermore, the website noted the registrants listed on the website were considered to be non-compliant (when a registrant failed to report changes in addresses, employment, vehicles owned or operated, etc.). Therefore, the online list was not intended to be a complete list of every registered offender.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly identify and follow contact precautions for 1 of 1 residents (R13) reviewed for transmission based precautions. 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	F 880	F880 **R-13 Is on contact isolation precautions. His pressure wounds were cultured and the final results. A sign has been placed on his room door indicating contact precautions and for visitor to see nurse at station prior to entering. C-diff precautions had been removed a few weeks prior to 1-27-2020. **There is one other resident (MB)who is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 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). R13's order summary report dated 12/19/19 identified contact isolation due to multiple drug resistant organism (MDRO occurs when bacteria or other microorganisms become resistant to antibiotics). Contact isolation identifies a process for staff and visitors to glove and gown in order to protect themselves and other residents. During observation on 1/27/20, at 1:08 p.m. personal protective equipment (PPE) was on the floor outside and to the left of R13's door. There was no sign on R13's door identifying precautions. After knocking and asking permission to enter, R13 stated, "You better gown up." When interviewed on 1/27/20, at 1:21 p.m. nursing assistant (NA)-D stated R13 was not on any precautions. When interviewed on 1/27/20, at 1:22 p.m. license practical nurse (LPN)-E stated R13 was on contact precautions for C diff. During observation on 1/28/20, at 11:13 a.m. PPE supplies outside and to the left of R13's door. No sign on the door that indicated contact	F 880	on Droplet Precautions. There are signs on her door indicating such. Resident and Staff have been educated on Droplet Precautions. **When other residents are identified as requiring Transmission based Precautions that will be communicated at our daily morning meeting. On weekend and after hours the Bldgs. charge or supervisor will commuicate this information. There is also a communication book now at each station . All department staff working on the unit are required to read this book. **Policy & Procedure for Contact Precautions has been reviewed and revised to reflect current standards of practice. All Facility Staff will be educated on revised Policy & Procedure for Contact Precautions. **Facility will identify and follow contact precautions related to transmission-based precautions. **Audits will be conducted with room isolation set up & staff adherence to correct precaution protocol. Once per shift weekly x 8 weeks until 100% compliance as determined by the QAPI Committee. **Responsible Person: Infection Control Specialist /Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880		

precautions.

During observation on 1/29/20, at 8:00 a.m. PPE remained outside and to the left of R13's door and a contact precautions sign was now displayed on R13's door.

During observation on 1/29/20, 11:14 a.m. LPN-C opened R13's door with foot and then entered room with beverages in hands. LPN-C was not wearing gown or gloves. LPN-C set beverages down on the bed side table. LPN-C then gloved one hand and pulled door closed with gloved hand. No hand hygiene was performed either before or after this.

During observation on 1/29/20, at 11:29 a.m. trained medication assistant (TMA)-A entered room and dropped off cereal, bowl and milk. TMA-A did not glove or gown. TMA-A used alcohol based hand rub (ABHR) prior to leaving room and pulled door closed with ungloved and sanitized hand.

During observation on 1/29/20, at 12:48 p.m. LPN-C entered R13's room to answer call light. LPN-C did not apply gloves or gown. R13 stated needed urinal emptied. LPN-C stated, "Ok, let me gown up for that." LPN-C stepped out of 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40	F 880		

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."

When interviewed on 1/30/20, at 7:58 a.m. director of nursing (DON) stated it was not necessary to gown and glove when someone is on contact precautions and staff do not touch the linens or perform cares. DON further stated when working directly with the wound, staff should gown and glove. DON further stated, "I hope there is not a sign on the door, [stating contact precautions]. It should just say check with nursing station, for dignity and such."

When interviewed on 1/30/20, at 8:23 a.m. infection control nurse RN-A stated, "There should be a sign on the door to say what the type of precaution and what PPE was needed. You cannot go into a contact precautions room without gowning even if just dropping something off. Regardless of what infection." RN-A further stated staff were trained annually on isolation precautions.

The facility policy Infection Control Isolation Precautions dated 10/18, indicated contact precautions were to be in place for residents with known or suspected infections that could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 transmitted by direct contact with resident or indirect contact with environmental surfaces or resident care items. The policy instructed staff and visitors to wear gloves when entering room. The policy further instructed staff and visitors to wear a disposable gown upon entering the room and to remove gown and gloves prior to leaving room. The policy further instructed staff to perform hand hygiene after removing gloves before leaving the room.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 42 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to offer an influenza vaccination for 1 of 5 residents (R234) reviewed for immunizations. Findings include: R234's Admission Record form showed R234 admitted to the facility 1/14/20. On the date of admission, R234 signed a Resident/Patient Immunization Consent or Declination form, giving	F 883	F883 **R234 refused immunization and documentation completed per facility policy, education provided to resident and consent received. **Facility will offer influenza & Pneumococcal vaccine to all residents upon admission or request documentation of completion prior to admission. Declination form to be signed if refusal of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 43 consent to receive the influenza vaccine. The signature indicated consent was given after education of risk and benefits had been provided. R234's Immunization Report from the electronic medical record on 1/30/20, did not provide evidence that the facility had provided the influenza vaccine to R234 since admission. The record indicated the last known historical influenza vaccination was given 3/27/16. During interview on 1/30/20, at 2:02 p.m. the director of nursing (DON) stated he expected residents to be offered the influenza vaccine throughout the entire influenza (flu) season as the facility intended to have enough of the vaccine onsite to offer residents the option of vaccination throughout the entire season, or longer if the doctor recommended. The Centers for Disease Control and Prevention (CDC) Vaccine Information Statement dated 8/15/19, noted that influenza activity spreads around the United States each year, usually between October and May. The facility policy, Influenza Vaccination - Resident/Patient, last revised November 2016, recognized the "major impact and mortality of influenza disease on residents of nursing homes and the effectiveness of vaccines in reducing health care costs and preventing illness, hospitalization and death." The policy required all residents to be offered and encouraged to receive the flu vaccine annually, unless contraindicated or a resident already received the vaccine for that season. Newly admitted residents would be offered the vaccine according to calendar schedule per CDC recommendations for annual	F 883	vaccine's. The Facility immunization policy and procedure has been reviewed and revised to include 0ffering on admission and Annual involvement from QAPI **Audit to be done of immunizations within 7 days of admission. **Audtits will be completed weekly on new admissions for Influenza vaccine and Pneumococcal every week x2 months until 100% as determined by the QAPI **Responsible Person: Health Unit Coordinator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 01/30/2020

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 44 vaccine (usually October through March). Immunization status for each resident was to be determined prior to vaccination, and then a signed informed consent would occur prior to vaccination.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey (Bay View - previously Red Wing Health Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Red Wing Health Center (new name Bay View) is a 3-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1972, addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1999 a small addition was added to the west wing. Because the original building and the 2 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 130 beds and had a census of 87 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear accessibility to the fire alarm system in accordance with the Life Safety Code NFPA 101 - 2012 edition (9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72) 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: During walk-through of the facility observed obstructed access to fire alarm pull-station (BASEMENT - LOADING DOCK AREA) This deficient practice was confirmed by the	K 345	K345: During Walk-through of the facility FM observed obstructed access to fire alarm pull station. *Correction: **Items removed form the pull station and signs will be placed to remind staff and others to not stack supplies in these areas. Responsible Person: Maintenance Director	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 Facility Maintenance Director at the time of discovery.	K 345		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinkler head clearances in accordance with the Life Safety Code NFPA 101 - 2012 edition (9.7.5, 9.7.7, 9.7.8, and NFPA 25) 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:	K 353	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 would not obstruct fire sprinkler Responsible Person: Maintenance Director/Designee	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 During walk-through of the facility observed: (1) High storage in proximity to sprinkler head outside of RM 2-205 (2ND FL) (2) Obstructed sprinkler heads in walk-in freezer (BASEMENT) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear accessability to fire extinguishers in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.3.5.12, NFPA 10) 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: During walk-through of the facility observed obstructed access to fire extinguisher (BASEMENT - LOADING DOCK AREA)	K 355	K355 *Items blocking the fire extinguisher where removed from location and signs place to inform staff and other not to store materials in this area. * Monthly audits will be conducted for the Month of March and April and if 100% compliant safety committee will discontinue audits. *Person responsible: Maintenance Director	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain utilities access security in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.5.1.1, 9.1.1, 9.1.2, NFPA 70) 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: During walk-through of the facility observed - unsecured electrical panel in the resident corridor adjacent to RM 2-203 (2ND FL) This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 511	K511 During walk through FM found unsecured electrical panel door in corridor 2E *Correction: **Secured panel door contacted maintenance personal to double check panel doors after contractors work on the electric doors or any other times contractor have to access electrical panels for service. Responsible Person: Maintenance Director/Designee	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 6 discovery.	K 511		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility's general ventilating and air conditioning system (HVAC) is not installed and tested in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. 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 interviews revealed the following: The ventilation system on the 1st, 2nd, and 3rd floors in the 1965 addition utilizes the egress corridor as the return air for the resident rooms. (WAIVER TO BE SUBMITTED) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 521	K521 Annual Waiver for HVAC to be submitted by John Donham Responsible Person: Maintenance Director/Designee	3/17/20
K 712	Fire Drills	K 712		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712 SS=F	Continued From page 7 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain consistancy in conducting fire drills in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.7.1.4 through 19.7.1.7) This deficient practice could affect 87 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 01/29/2020, observation and documentation reviewed revealed the following: During documentation review - no records were provided to confirm that fire drills were conducted: Q3 2019 (3rd shift); Q4 2019 (1st shift) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	K712 During Documentation review FM found no records were provided to confirm fire drills conducted on Q3 2019 (3rd shift) and Q4 2019(1st Shift). *Correction: **Fire drills will be reviewed during monthly QAPI/Safety meetings two ensure conducted properly. Responsible Person: Maintenance Director/Designee	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 8 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier and fire rated doors in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (2010 NFPA 80)) 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: During walk-through of the facility observed the following: (1) Fire rated door (#52) exhibited a gap at the top of the door > 3/8" (2ND FL) (2) Smoke Barrier doors located on 1ST and 2ND FL exhibited gaps > 1/8" (3) Smoke Barrier door hardware did not close and latch properly (3RD FL - Physical Therapy	K 761	K761 1.During walk through FM found gape on top of door #52 >3/8 **Correction: Door is being evaluated for repairs 2.During walk through FM found smoke barrier doors exhibited gaps>1/4 after close **Correction: Bulb seals will be placed in all smoke barrier doors to close gap<1/4 3.FM found smoke barrier door on 3E PT did not close and latch properly **Correction: Replace door hardware Responsible Person: Maintenance Director/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 9 Area) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 761		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly use electrical devices in accordance with the Life Safety Code NFPA 101 - 2012 edition (10.2.4., 10.2.3.6 (NFPA 99), 10.2.4	K 920	K920 1. During walk through FM observed the following: (1) appliance connected to power strip nursing office and business	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2020**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 10 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) 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: During walk-through of the facility observed the following: (1) Appliance connected to power-strips the Nurses Office (1ST FL) (2) 6-plex electrical adapter inserted to wall duplex in Beauty Shop (2ND FL) (3) Power strips daisy-chained in RM 14A (1ST FL) (4) Appliance connected to power-strip in Business Office - RM A13 (1ST FL) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	office. **Correction: 2. Unplugged the appliance and plugged directly to outlet, education to be provided to all staff on proper use of power strips. During walk through FM found daisy chain of power strip on 1st floor owners office **Correction: Removed additional power strip from office, education to be provided to all staff on proper use of power strips. 3.During walk through FM found 6plex plugged into outlet in nurse coordinators office on 2E **Correction: Removed 6 plex Education to be provided to all staff on what is authorized to be used in the facility according to state. Responsible Person: Maintenance Director/Designee	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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.

Sincerely,

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: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/27/19 through 1/30/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. In addition, complaint investigations were also completed at the time of the licensing survey.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 An investigation of complaint's H5223171C, H5223172C, H5223173C, H5223174C, H5223175C, H5223170C, H523178C and H5223176C was completed. The complaint's were not substantiated. An investigation of complaints H5223177C and H5223179C was completed. The complaints were substantiated but no correction orders were issued at State Licensing. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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	2 000		
2 005	MN Rule 4658.0015 COMPLIANCE WITH REGULATIONS AND STANDARDS A nursing home must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in a nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to notify 43 of 88 current residents of a registered sex offender living in the facility. Findings include: R77's Admission Record form showed R77 admitted to the facility 8/3/18. R77's quarterly Minimum Data Set (MDS) assessment described R77 as having moderately	2 005	Corrected	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE 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.

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 involved in sexual behaviors/aggression toward other residents.

R77's medical record contained a Fact Sheet dated 8/3/18. The form was self titled as, "Information on a Registered Offender," and was "For Distribution to Facility Residents." Red Wing Police Department provided the Fact Sheet to the 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 R77 as risk level two, with conviction for criminal sex conduct (two counts) in 1993, of two female children known to R77.

On 1/30/20, at 10:59 a.m. the director of social

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 005	Continued From page 4	2 005		

services (DSS) stated R77 had not wandered into any other resident rooms, touched people, or gotten close to anyone else. DSS stated the police department sent the Fact Sheet about R77's convictions after R77 was already admitted to the facility, and DSS personally distributed the notice to every resident and guardian at that time. DSS described having conversations with people to ensure they understood what the notice meant. Since 8/7/18, no new admissions had been notified of R77's convictions, because when staff searched for R77 on the online registry, R77's name did not come up. Registered nurse (RN)-E described searching for R77's name on an online registry at the time of receiving the Fact Sheet from the police, and being unable to find R77's name at that time. RN-E searched for R77's name multiple times on the online list, and never found it, so despite the Fact Sheet, RN-E was confused about whether R77 was truly a registered offender requiring notification to all the residents.

The current census list included 88 residents (including two residents currently in the hospital), and 43 of those residents were admitted after the initial notification took place on 8/7/18.

A facility policy on admitting registered offenders, and notifying residents of registered offenders was requested, but not provided. RN-E confirmed on 1/30/20, that the facility did not have such a policy.

The Minnesota (MN) Bureau of Criminal Apprehension Predatory Offender Registration website explained convictions of criminal sexual conduct required registration in MN. Additionally, risk level two indicated a moderate likelihood to re-offend. Furthermore, the website noted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 005	Continued From page 5 registrants listed on the website were considered to be non-compliant (when a registrant failed to report changes in addresses, employment, vehicles owned or operated, etc.). Therefore, the online list was not intended to be a complete list of every registered offender. SUGGESTED METHOD OF CORRECTION: The administator or designee could review and revise policies and procedures related to admission of registered sex offenders, and the required notification for all residents residing in the facility with a registered sex offender. The administrator or desginee could audit all residents to ensure appropriate notification to residents, and/or resident representatives or guardians. The administrator or designee could develop policy and procedure that would ensure appropriate notification to future admits. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 005		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure pool (temporary agency)staff were trained and competent to provide tracheostomy (tube inserted through an	2 300	Corrected	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 300	Continued From page 6 opening in the neck into the windpipe) care and suctioning for 1 of 3 residents (R41) reviewed for mechanical ventilation/tracheostomy. Findings include: R41's quarterly Minimum Data Set (MDS) dated 12/9/19, identified R41 was cognitively intact and required extensive physical assistance with support of two plus persons for most activities of daily living (ADLs). The MDS further identified R41's diagnoses of acute respiratory failure with hypoxia (decreased level of oxygen available for body tissues), morbid obesity, and tracheostomy (trach) status. R41's care plan (CP) last reviewed 1/18/20, indicated R41 was ventilator (vent) dependent related to impaired breathing mechanics at night. The CP instructed staff to assess for signs and symptoms of hypoxia. The CP further indicated the ventilator settings and nebulizer treatments via the trach. When interviewed on 01/27/20, at 2:37 p.m. R41 stated pool staff do not perform proper trach care. R41 stated one pool nurse, licensed practical nurse (LPN)-F made (R41) bleed, "not too long ago" during suctioning. During observation on 1/29/20, at 8:11 a.m. LPN-C entered R41's room to remove from vent and provide trach suctioning. LPN-C applied gloves, vent was disconnected, and humidified oxygen placed to trach via trach dome. LPN-C retrieved a suction kit, removed gloves, and used alcohol based hand rub (ABHR). Sterile gloves applied from suction kit. Balloon deflated and trach suctioned three times. Balloon inflated. LPN-C then used a Yankauer (suction tip) to	2 300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 300	Continued From page 7 suction mouth. LPN-C removed gloves and washed hands. When interviewed on 1/29/20, at 9:02 a.m. R41 stated, "I think it was a pool nurse, did not deflate the cuff prior to suctioning." R41 further stated, "I needed suctioning and [registered nurse (RN)-D] did not deflate the balloon and did not get anything out with the suction." R41 stated, "When I told [RN-D], he told me I am supposed to remind him. I told [RN-D] you are supposed to know that." R41's progress note by RN-D dated 1/29/20, at 3:08 a.m. indicated R41 requested suctioning at 1:00 a.m. Progress note included, RN-D deflated balloon before suctioning resident and inflated balloon prior to leaving R41's room. The progress note further indicated RN-D checked on R41 at 3:00 a.m. when R41 told RN-D that RN-D did not deflate the balloon before suctioning last time. When interviewed on 1/29/20, at 01:14 p.m. LPN-C stated, "You don't always have to deflate the cuff prior to suctioning but with [R41] you do. [R41] has granulomas [growth] forming and if you do not deflate the cuff first you can either not pass by them or nick them and cause bleeding." When interviewed on 1/30/20, at 7:43 a.m. director of nursing (DON) stated the facility recently experienced some staff turnover. DON stated the previous nurse manager provided most of the vent/trach training to staff. A respiratory therapist from the facility's contracted respiratory vendor also supplied some training to staff. DON stated RN-A was the new trainer and would be able to provide more information about training. Pool staff would work with regular staff nurses like LPN-C. DON stated, "We would not put	2 300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 300	Continued From page 8	2 300		

anyone down there without experience or alone. [LPN-F] is a pool nurse and has been doing great down there working with [LPN-C]. I think [RN-D] is pool staff." RN-B was also in the office and confirmed RN-D was a pool RN. LPN-D also in the office confirmed the previous nurse manager did most of the vent training. LPN-D stated, "pool staff get training from regular staff prior to working their first shift. DON confirmed and stated, RN-A used to be a nurse on the floor at the facility and was now the staff trainer and infection control nurse. DON further stated, "[RN-A] is developing a training program. The competency check off is pretty weak. We had to scrape from the previous person. We had a check off list and it was not accurate. We have to change this."

When interviewed on 1/30/20, at 8:30 a.m. RN-A stated, "Packets for pool are supposed to be done before the first shift. They come in early. I would be responsible to check them off." RN-A confirmed pool staff were "checked off just prior to their first shift from whatever staff is here." RN-D's competency checklist could not be located in RN-A's office. RN-A stated, "I have worked with [RN-D] here before." RN-A further stated RN-D did not perform vent/trach cares on that shift. RN-A stated, "[RN-D] has been here a month or two and I know that when [RN-D] was working with me did not do those skills and left them for me to complete. RN-A stated [RN-D] reported not feeling comfortable completing those cares (vent/trach) independently. RN-A confirmed the facility cannot produce any documentation that RN-D received vent/trach training or that RN-D was competent from previous training.

When interviewed on 1/30/20, at 11:05 a.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 300	Continued From page 9 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. When interviewed on 1/30/20, at 1:20 p.m. RN-D confirmed not having specific vent/trach training at the facility. RN-D confirmed having four hours of orientation prior to the start of first scheduled shift with LPN-C, but the training did not include how to suction or care for vents/tracheostomy's. RN-D further confirmed there was no checklist to sign off for competencies. R41's treatment administration record (TAR) indicated, "Suctioning: May suction as needed every shift for excessive secretions/respiratory distress to maintain airway; Document total number of times suctioned each shift." R41's TAR indicated RN-D suctioned R41 once during the night shift on 1/29/20. The undated facility Trach Stoma Care, Cleaning and Suction Competency identified a competency checklist with specific steps to be observed and checked off by a nurse. RN-D's competency checklist was requested but not provided. The facility policy Suctioning Lower Airway (Endotracheal or Trach Tube) revised 3/14, identified the procedure for removing secretions in order to maintain an open airway and prevent infection. The policy indicated the necessary supplies, what to assess, and step by step procedure for suctioning. The policy identified trach suctioning is a sterile procedure. The policy also indicated that there are possible complications such as trauma to the airway,	2 300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 300	Continued From page 10 infection, and hypoxia if the procedure was not done correctly. The facility policy Competency of Nursing Staff revised 10/17, indicated all licensed nursing staff employed or contracted will participate in a facility-specific, competency-based staff development and training program. The policy further indicated licensed nurses would demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents. The policy further indicated the competency based staff training program would contain specialized skills needed based on the resident population. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to tracheostomy and ventilator care. DON could provide training to the nurses, including pool nurses, along with completing competency skills in this area. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 300		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced	21375		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 11 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. 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). R13's order summary report dated 12/19/19 identified contact isolation due to multiple drug resistant organism (MDRO occurs when bacteria or other microorganisms become resistant to antibiotics). Contact isolation identifies a process for staff and visitors to glove and gown in order to protect themselves and other residents. During observation on 1/27/20, at 1:08 p.m. personal protective equipment (PPE) was on the floor outside and to the left of R13's door. There was no sign on R13's door identifying precautions. After knocking and asking permission to enter, R13 stated, "You better gown up."	21375	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 12 When interviewed on 1/27/20, at 1:21 p.m. nursing assistant (NA)-D stated R13 was not on any precautions. When interviewed on 1/27/20, at 1:22 p.m. license practical nurse (LPN)-E stated R13 was on contact precautions for C diff. During observation on 1/28/20, at 11:13 a.m. PPE supplies outside and to the left of R13's door. No sign on the door that indicated contact precautions. During observation on 1/29/20, at 8:00 a.m. PPE remained outside and to the left of R13's door and a contact precautions sign was now displayed on R13's door. During observation on 1/29/20, 11:14 a.m. LPN-C opened R13's door with foot and then entered room with beverages in hands. LPN-C was not wearing gown or gloves. LPN-C set beverages down on the bed side table. LPN-C then gloved one hand and pulled door closed with gloved hand. No hand hygiene was performed either before or after this. During observation on 1/29/20, at 11:29 a.m. trained medication assistant (TMA)-A entered room and dropped off cereal, bowl and milk. TMA-A did not glove or gown. TMA-A used alcohol based hand rub (ABHR) prior to leaving room and pulled door closed with ungloved and sanitized hand. During observation on 1/29/20, at 12:48 p.m. LPN-C entered R13's room to answer call light. LPN-C did not apply gloves or gown. R13 stated needed urinal emptied. LPN-C stated, "Ok, let me gown up for that." LPN-C stepped out of	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 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."

When interviewed on 1/30/20, at 7:58 a.m. director of nursing (DON) stated it was not necessary to gown and glove when someone is on contact precautions and staff do not touch the linens or perform cares. DON further stated when working directly with the wound, staff should gown and glove. DON further stated, "I hope there is not a sign on the door, [stating contact precautions]. It should just say check with nursing station, for dignity and such."

When interviewed on 1/30/20, at 8:23 a.m. infection control nurse RN-A stated, "There should be a sign on the door to say what the type of precaution and what PPE was needed. You cannot go into a contact precautions room without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 14 gowning even if just dropping something off. Regardless of what infection." RN-A further stated staff were trained annually on isolation precautions. The facility policy Infection Control Isolation Precautions dated 10/18, indicated contact precautions were to be in place for residents with known or suspected infections that could be transmitted by direct contact with resident or indirect contact with environmental surfaces or resident care items. The policy instructed staff and visitors to wear gloves when entering room. The policy further instructed staff and visitors to wear a disposable gown upon entering the room and to remove gown and gloves prior to leaving room. The policy further instructed staff to perform hand hygiene after removing gloves before leaving the room. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies, educate staff and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 15 This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure tuberculosis (TB) symptom screens were completed within 72 hours of admission for 2 out of 5 residents (R30 and R234) reviewed for TB screening. Findings include: R30's Admission Record form showed an admit date of 8/26/19. Staff administered the first tuberculin skin test on 8/26/19, but did not provide evidence of completing a TB history or symptom screen within 72 hours of admission. R234's Admission Record form showed an admit date of 1/14/20. Staff administered the first tuberculin skin test on 1/14/20, but did not provide evidence of completing a TB history of symptom screen within the first 72 hours of admission. On 1/30/20, at 12:22 p.m. registered nurse (RN)-A confirmed being unable to find documentation of a TB history or symptom	21426	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 16 screen for R30 or R234. The Tuberculosis Prevention and Control Program, revised January 2020, included, "Early identification and management of person with TB is essential." The policy did not specify the timeline in which the TB history and symptom screen needed to be completed for a newly admitted resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents are screened for physical signs and symptoms of active TB disease on admission. The DON or designee could educate the appropriate staff on the policies/procedures, and could develop a monitoring system by auditing residents' charts to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any	21530		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 17 irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to address pharmacy recommendations for 1 of 5 residents (R30) reviewed for unnecessary medications. Findings include: R30's quarterly Minimum Data Set (MDS) assessment 11/25/19, described R30 to have diagnoses including mood disorder, mental disorder, and traumatic subdural hemorrhage	21530	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 18	21530		

without loss of consciousness. R30 was taking antipsychotics on a routine basis, and received an antipsychotic medication seven out of seven days during the look back period, with no gradual dose reduction yet attempted since admit 8/26/19.

R30's physician order dated 11/2/19, for 12.5 milligrams (mg) of quetiapine fumarate, an antipsychotic medication, was scheduled at bedtime for unspecified mood affective disorder.

R30's Consultant Pharmacist's Medication Review dated 12/20/19, recommended the facility, "add orders for antipsychotic monitoring including patient specific target behaviors, side effects, and orthostatic blood pressures." R30's orders did not provide evidence that the facility was monitoring R30 for side effects related to antipsychotic medication use, or target behaviors.

R30's sleep care plan initiated 11/13/19, noted R30's inability to sleep well due to anxiety. One of the interventions was to give R30 quetiapine per doctor orders. Nowhere else on the care plan did the facility address the antipsychotic medication, or monitoring for side effects and target behaviors.

When interviewed on 1/29/19, at 2:03 p.m. licensed practical nurse (LPN)-A stated that side effect and target behavior monitoring should be in the treatment administration record (TAR), as the nurses had to watch for side effects and target behaviors in residents taking antipsychotic medications during their shift, and document if they saw any concerns on the TAR. LPN-A reviewed R30's orders and did not find an order for side effect or target behavior monitoring. R30's TAR did not provide evidence of side effect/target behavior monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 19 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. R30's progress notes dated 8/31/19, and 11/27/19, included notes that a different pharmacist had reviewed R30's medication regimen, and made recommendations that needed to be reviewed. The pharmacist's recommendations could not be located in the electronic medical record. The recommendations were requested but not provided. The current Pharmacy Services procedure revised April 2014, required the pharmacist to review each resident's medication regimen at least monthly, and to communicate potential or actual problems detected and document findings and recommendations. This policy did not specify how the facility should respond to and maintain recommendations. The Psychopharmacologic Medication Assessment and Review plan revised November 2017, required all residents on a psychopharmacological medication to be monitored for side effects. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities including	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 20 policies related to medication monitoring systems to check side effect monitoring. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely, irregularities are being acted upon and potential side effects are regularly being monitored. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to monitor for potential side effects for 1 of 2 residents (R13) reviewed who received an anticoagulant (blood thinner) medication. In addition, the facility failed to ensure residents taking psychotropic medications were monitored for side effects and target behaviors for 2 of 5 residents (R30 and R77) reviewed for unnecessary medications. 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 of deep vein thrombosis (blood clot), and peripheral vascular disease (impaired blood flow to extremities). The MDS further indicated R13 received an anticoagulant seven of the seven days prior to the assessment. R13's care plan dated 11/7/19, failed to address R13's anticoagulant administration and did not instruct staff to monitor for side effects of this medication. When interviewed on 1/27/20, at 1:18 p.m. R13 stated he was taking a blood thinner daily and, "I had blood in my urine two weeks ago." When interviewed on 1/27/20, at 1:18 p.m. licensed practical nurse (LPN)-C stated when a resident is on a blood thinner, "We look for bruising, and monitor other things. Can I look in the TAR [treatment administration record]?"	21540	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 22 LPN-C opened a different resident's electronic medical record (eMR) and confirmed residents on anticoagulants were monitored for the following: "discolored urine, black tarry stools, sudden severe headache, N&V [nausea and vomiting], diarrhea, muscle joint pain, lethargy [lack of energy and enthusiasm], bruising, sudden changes in mental status and/or V/S [vital signs], SOB [shortness of breath], nose bleeds." LPN-C further stated the nurses monitor for side effects of all anticoagulants including Eliquis and Xarelto. LPN-C stated, "Only the LPNs mark those [on the TAR], TMAs [trained medication aide] do not." When interviewed on 1/30/20, at 8:02 a.m. LPN-D confirmed anticoagulant side effects should be monitored every shift and documented on the TAR. Registered nurse (RN)-B stated, "It should be in the orders [to monitor the side effects]." RN-B accessed R13's eMR and confirmed R13 was taking Xarelto. RN-B further verified and stated, "It would have to be in here [the TAR] if we are checking for side effects. There is no order in [R13's] chart." RN-B further confirmed it would not be a direct order from the provider because it is a template that the facility used. Director of nursing (DON) verified and stated, "Nurses should check side effects when a resident is on an anticoagulant." DON further stated, the order for monitoring side effects was supposed to be selected when the order for the anticoagulant was entered into the eMR. When interviewed on 1/30/20, at 9:16 a.m. pharmacist confirmed side effects should be monitored with residents taking Xarelto. Pharmacist further confirmed the protocol for anticoagulant side effect monitoring should be entered into the eMR by the facility staff.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 23 R13's order summary report as of 1/30/20, included an order for 20 mg Xarelto with an order date of 12/19/19 for acute embolism (a blood clot, foreign object, or other bodily substance that becomes stuck in a blood vessel) and thrombosis of left popliteal (back part of the leg behind the knee joint) vein. R13's order summary report failed to include the order for monitoring side effects of the anticoagulant. R13's TAR for December 2019 and January 2020 failed to include monitoring for side effects of an anticoagulant. The facility policy Anticoagulation with Warfarin, Low Molecular Weight Heparin, or Lovenox revised 11/14 identified process for staff to monitor for complications of anticoagulation therapy. The policy instructed staff to monitor for side effects such as hematuria (blood in the urine), hemoptysis (coughing up blood), and any other evidence of bleeding. R30's quarterly Minimum Data Set (MDS) assessment 11/25/19, described R30 to have diagnoses including mood disorder, mental disorder, and traumatic subdural hemorrhage without loss of consciousness. R30 was taking antipsychotics on a routine basis, and received antipsychotic medications seven out of seven days during the look back, with no gradual dose reduction yet attempted since admit 8/26/19. R30's physician order dated 11/2/19, for 12.5 milligrams (mg) of quetiapine fumarate, an antipsychotic medication, was to be given at bedtime related to R30's diagnosis of unspecified mood affective disorder.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 24 R30's Consultant Pharmacist's Medication Review dated 12/20/19, recommended the facility "add orders for antipsychotic monitoring including patient specific target behaviors, side effects, and orthostatic blood pressures." R30's orders did not provide evidence that the facility was monitoring R30 for side effects related to antipsychotic medication use, or target behaviors. R30's sleep care plan initiated 11/13/19, noted R30's inability to sleep well due to anxiety. One of the interventions was to give R30 quetiapine per doctor orders. Nowhere else on the care plan did the facility address the antipsychotic medication, or monitoring for side effects and target behaviors. When interviewed on 1/29/19, at 2:03 p.m. licensed practical nurse (LPN)-A stated side effect and target behavior monitoring should be in the treatment administration record (TAR), as the nurses had to watch for side effects and target behaviors in residents taking antipsychotic medications during their shift, and document if they saw any concerns on the TAR. LPN-A reviewed R30's orders and did not find an order for side effect or target behavior monitoring. R30's TAR did not provide evidence of side effect/target behavior monitoring. 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.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 25 R77's quarterly MDS assessment dated 1/7/20, included moderate cognitive impairment with diagnoses including non-Alzheimer's dementia, and post traumatic stress disorder. R77 received an antipsychotic medication 7 out of 7 days during the look back period, with a gradual dose reduction attempted 2/19/19. R77 did not ambulate during the seven day look back period, but needed extensive assist of two staff to transfer. R77's Admission Record form included diagnoses of repeated falls, and recurrent severe major depressive disorder without psychotic features. R77's physician order dated 7/5/19, for antipsychotic medication Seroquel (quetiapine fumarate), at 300 mg each night before bed related to post traumatic stress disorder. R77 also had orders for staff to check orthostatic blood pressures (blood pressure checks performed in succession while laying, then sitting, then standing) monthly on the 15th of every month. Orthostatic blood pressure measures for drops in blood pressure as a person moves from laying down, to sitting, to standing. The Seroquel Medication Guide on the Food and Drug Administration website notes one possible side effect of taking Seroquel is decreased blood pressure (orthostatic hypotension), "including lightheadedness or fainting caused by a sudden change in heart rate and blood pressure when rising too quickly from a sitting or lying position." R77's transfers/mobility care plan initiated 8/7/18, described R77 to need supervision with transfers in and out of bed, to the wheelchair, and to the toilet. The care plan noted R77 often did not wait for staff or would not ask for staff assist and	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 26 would self transfer. The care plan also noted R77 had falls related to unsteady gait. The care plan described R77 to be taking psychotropic medications, such as Seroquel, and to monitor for negative side effects of the medication, for example monthly orthostatic blood pressure. R77's TAR included a place for staff to document monthly orthostatic blood pressure measurements on the 15th of every month. Staff did not document orthostatic blood pressure on the TAR in January 2020. Review of the Weights and Vitals Summary showed the last documented orthostatic blood pressure check on 12/15/19. Interview on 1/30/20, at 9:15 a.m. Pharmacist-E explained his monthly visits included reviewing residents for side effect monitoring, and confirmed orthostatic blood pressure checks were part of side effect monitoring for residents taking antipsychotic medications who may be ambulatory. The Psychopharmacologic Medication Assessment and Review plan revised November 2017, required all residents on a psychopharmacological medication to be monitored for side effects. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		