DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 31, 2022

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 27, 2022 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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May 31, 2022

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

RE: CCN: 245223
Cycle Start Date: March 17, 2022

Dear Administrator:

On April 12, 2022, we notified you a remedy was imposed. On May 6, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 27, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 12, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 12, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 27, 2022, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
April 12, 2022

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

RE: CCN: 245223
Cycle Start Date: March 17, 2022

Dear Administrator:

On March 17, 2022, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 12, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 12, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 12, 2022.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by May 12, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bay View Nursing & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
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: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 17, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

DIRECTED PLAN OF CORRECTION - Personal Protective Equipment (PPE)

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, with Governing Body oversight must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. Information regarding RCAs is available in the Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

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

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care..

- Develop and implement a policy and procedure for source cotrol masks.

- Develop and implement a policy and procedure for proper use of gowns.

- Review policies regarding standard and transmission-based precautions and revise as needed.

TRAINING/EDUCATION:

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

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

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

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

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

RESOURCES:

Superior Health Quality Alliance:
https://www.superiorhealthqa.org/
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/ Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html
Strategies for Optimizing the Supply of N95 Respirators:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
Strategies for Optimizing the Supply of Facemasks
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html
Using Personal Protective Equipment PPE:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
ShapeMDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF):
https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.

- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors, and residents.

- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.

- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on proper use of gowns to ensure PPE is in use.

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

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter.

To successfully complete the DPOC, the facility must provide documentation to support evidence the DPOC was completed.

- Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

- A revisit will not be completed prior to receipt of documentation confirming the DPOC was completed.

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

EPOC:

The ePOC system is programmed, so the facility cannot upload additional documents after MDH formally accepts the Plan of Correction through the EPOC system.

To resolve this, after the POC is received, and meets all the required POC components. The supervisor will reject the POC for F880 in the system, BUT will identify in the comment section, "POC accepted but waiting additional documents complete DPOC process."

By completing this process the ePOC portal opens for the facility to upload the final DPOC documents for review.

If additional information is required for the POC, the supervisor will identify this in the comment section.

Adding attachments DPOC:

When adding DPOC attachments, the software does not have a limit to the number of attachments, but each attachments cannot be greater than 4MB. If this occurs, the attachment will not upload in the ePOC system.

ASPEN web ePOC guide for providers:
https://qtso.cms.gov/system/files/qtso/ePOC-Fac_PG_11.9.4.2_FINAL.pdf

Training videos for ePOC provider: https://qtso.cms.gov/training-materials/epoc-providers

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

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and interventions/correction action plan, reviewed with QA committee and Governing Body President with confirmation this was completed.
2	Documentation that the interventions or corrective actions plan that resulted form the RCA was fully implemented.
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training.
4	Names and positions of all staff that attended trainings, include sign-in sheet.
5	Summary of staff training post-test results, if applicable and include any follow up in response to failed tests.
6	Documentation of completed audit forms and any follow up action taken from failed audits.

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 03/17/2022

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 March 14, 2022, through March 17, 2022 during a recertification survey. The facility is was IN compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/14/22, through 3/17/22, a standard survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5223247C (MN81607). However, no citations were issued due to actions taken by the facility prior to entrance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		4/27/22

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

Electronically Signed | 04/22/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENTER	**1412 WEST FOURTH STREET RED WING, MN 55066**

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F 584	Continued From page 1 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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 03/17/2022

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 584	Continued From page 2 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and comfortable environment for 1 of 1 residents (R27) who had concerns with odors in his room. Findings include: R27's annual Minimum Data Set (MDS) dated 10/6/21, identified cognitively intact, and required extensive assistance from staff for hygiene, toileting, transferring, and bed mobility. R27 had no behaviors and was occasionally incontinent of bladder. During observation on 3/14/22, at 6:00 p.m. a strong odor of urine was noted from R27's room. On the floor at the end of the bed was a six inch wide by two foot wide area of dried dark yellow color substance. During observation and interview on 3/15/22, at 8:35 a.m. a pungent urine odor was noted inside R27's room and permeated into the hallway. R27 stated he was offended by the smell of the urine and the urine stain on the floor had been there for a couple days. R 27 stated he knew the facility was short staffed and didn't want to bother them. He further stated he assumed if the nursing staff saw the urine spill they would have cleaned it up and not wait for the housekeeping staff. On 3/15/22, at 8:56 a.m. director of respiratory therapy (DRT) who was the manager of the unit that day, verified R27's room had a strong odor of urine, a large area of dark yellow dried urine was	F 584	The plan and response to CMS 2567 is written solely to maintain certification in 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 their entirety should any remedies be imposed without jeopardizing the right to challenge the validity of the F-tags and without admitting that any non-compliance with this regulation exists. We have implemented the following measures: F584 Safe/Clean/Comfortable/Homelike Environment " R27□s room noted with strong urine odor and dried urine on floor was cleaned 3/15/2022. " Education provided to nursing staff and housekeeping staff on responsibility of cleaning resident areas if they are noted to be unsatisfactory. To be completed on or before 4/27/2022. To be completed by DON or Designee. " Audits to be completed weekly by housekeeping lead or designee of all resident rooms to include cleanliness and odor free environment. To be continued until the QAPI (Quality Assurance and Performance Improvement) team finds compliance is satisfactory or 100% compliance is met.	

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on the floor at the foot of bed, and two urinals with each of them containing about 100 milliliters (ml) that sat on R27's bedside table. DRT stated the nursing staff should have cleaned up the urine on the floor and emptied the urinals when providing care to R27. She further stated it was an infection control issue to leave urine on the floor or on the bedside table. DRT stated the housekeeping staff had been short staffed and had not been to the 2 East side the last couple days.

On 3/16/22, at 1:00 p.m. director of nursing (DON) stated her expectation for nursing staff was to ensure all urine spills were cleaned up immediately and not leave it to the housekeeping staff.

On 3/17/22, at 10:59 a.m. during the environmental tour of the facility the maintenance director (MD) verified R27's room had a significant odor of urine which permeated into the hallway. MD stated his expectation would be for nursing staff, once a spill of urine was on the floor, to wipe the urine up, and if housekeeping was available to contact housekeeping staff to mop the floor.

The facility untitled form dated 3/15/22, indicated a description of task for each housekeeper to complete throughout the day. The form further indicated the housekeeper should clean R27's room which included to mop the floor and complete an afternoon walk through to identify spills or odors.

A facility policy related to providing a homelike environment and/or control of odors was requested but was not provided by the facility.

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F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide meaningful activities for 4 of 11 residents (R1, R8, R35 and R42) reviewed for activities. Findings include: R1's admission Minimum Data Set (MDS) dated 9/8/21, indicated R1 had a traumatic brain dysfunction (TBI), attention deficit hyperactivity disorder, restlessness and agitation, anxiety disorder, major depressive disorder, and aphasia (difficulty speaking). R1's MDS further indicated R1 had moderate depression and disorganized thinking. R1's behavioral and emotional status Care Area Assessment (CAA) dated 9/8/21, indicated R1 triggered for behaviors and lacked the nature of the problem or input from the family. R1's CAA further lacked indication activity was triggered. R1's care plan dated 10/7/21, indicated R1 had a potential for activity deficit. R1's care plan	F 679	F679 Activities Meet Interest/Needs of Each Resident " R1□s Activity Assessment completed, Care plan reviewed and updated with specific activities preferred, Care Card updated. " R8□s Activity Assessment completed, Care plan reviewed and updated with specific activities preferred, Care Card updated. " R35 Activity Assessment completed, Care plan reviewed and updated with specific activities preferred, Care cared updated. " R42□s Activity Assessment completed, Care plan reviewed and updated with specific activities preferred, Care cared updated. " Activity calendars for each month put in resident rooms and placed in resident common areas to update on new activities being offered beginning 4/01/2022. " Care plan reviews to be completed by	4/22/22

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F 679	Continued From page 5 directed staff to allow for periods of rest as well as activity, provide CD's, and magazines of interest. R1's care plan indicated R1 was at risk for elopement and aimlessly wandered and directed staff to offered pleasant diversions of structured activities, food, conversation, television, and a book. R1's life enrichment daily charting sheet dated 2/22, indicated R1 was offered activities five days of 28 days in the month. Activities offered during the month of February were common area, purposeful wandering, television, socializing, and 1 on 1 visits. There was no other documentation of activities being offered or refused. R1's life enrichment daily charting sheet dated 3/1/22, to 3/17/22, indicated R1 was offered activities two times and consisted of activities offered during the month of March were common area, purposeful wandering, television, socializing, and 1 on 1 visits. There was no other documentation of activities being offered or refused for the month of March. R1's progress note (PN) dated 3/6/22, at 6:21 p.m. indicated R1 went into another resident's rooms and got into their beds, resident talked continuously, invaded staff and resident's personal space. R1's PN indicated food and drinks were offered. R1's progress notes lacked activity notes or activity assessments. During observation on 3/14/22, from 11:30 a.m. to 12:45 p.m. R1 walked continuously through the halls at a quick pace. R1 went in and out of her room, other residents' room, and the nurse's	F 679	DON and Director of Life Enrichment to make each Care plan resident specific to be reviewed quarterly by Life Enrichment Director to be completed by 4/22/2022. " Evaluations of residents activity preferences and participation to be completed quarterly by Life Enrichment Director. " Activity documentation placed in Point of Care, Life Enrichment staff educated on new process and expectations for charting. " Resident satisfaction Audits to be completed weekly by Life Enrichment Director or Designee to evaluate new activities process. Results of audits to be reviewed Monthly at QAPI.	

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charting room on the unit. No staff were observed to redirect R1 or offer activities. The television was on in the main lounge for the other residents.

During observation on 3/15/22, from 12:30 p.m. to 1:00 p.m. R1 wandered through the long hallway of the unit, walked into other resident's room, spoke unintelligible words very quickly to residents and staff. No staff were observed to redirect R1 or offer activities. The television was on in the main lounge for the other residents.

During observation on 3/16/22, at 2:30 p.m. to 3:00 p.m. R1 was not observed to attend activities or receive 1 to 1 activity from the activity or nursing staff. The television was on in the main lounge for the other residents.

On 3/14/22, at 12:45 p.m. R1's family member (FM)-A stated R1 used to be an activity director at a nursing home for 20 years, and she loved to walk the halls, interact with residents, offer activities, and enjoyed spending time 1 on 1 time with the residents. FM-A stated the only activity he had seen was the television on and felt if more activities were offered or structured activities were offered to R1 to participate in, it may help reduce R1's wandering and behaviors. FM-A further stated he felt R1 going into residents' room and attempting to talk with them, was her way of still working.

R8's face sheet dated 3/17/22, included, diagnoses of quadriplegia (paralysis of all four limbs) and major depressive mood disorder.

R8's activities CAA 7/26/21, indicated it was very important to do her favorite activities, listen to

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music, go outside, and somewhat important to do things with groups of people, be around pets, and have items to read.

R8's care plan dated 1/4/22, lacked any updates or revisions on her R8's activities since 1/7/20, for activities. R8's care plan directed staff to provide monthly activity calendars and assist R8 to plan for attendance to activity offerings.

R8's Life enrichment daily charting sheet dated 2/22, indicated R8 had 12 days with no activities offered from 2/1/22 to 2/28/22. No refusal was documented.

R8's Life enrichment daily charting sheet dated 3/22, indicated R8 had eight days with no activities offered from 3/1/22 to 3/14/22. No refusal was documented.

R8's activity participation progress note (PN) date 9/17/19, indicated R8 attended & actively participated in some cognitive, social, educational, musical, spiritual, creative & sensory, and manicure groups. PN further indicated R8 liked to be cognitively challenged and was sometimes deterred from participation in facilitated groups by the behaviors, various abilities, and limitations of others in attendance.

R8's activity participation progress note date 3/10/20, indicated R8 attended many scheduled activities, made her own choice on what she would like to attend, and participation level was high with most activities. PN further indicated R8 enjoyed painting, music groups, socials, cooking groups, crafts, and games.

On 3/14/22, at 2:56 p.m. R8 stated she was

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F 679	Continued From page 8 frustrated the only activity for a while has been bingo once a week, and that it got boring. R8 stated prior to COVID-19 more activities would be offered such as crossword puzzles, movies with popcorn, painting, Jeopardy, and other games. Currently, R8 stated for activity she would go up to the therapy department and ride the bike for 30 minutes a couple times a week. but it would be nice to have group activities or more structured activities offered. R8 stated she was unsure if there was an activity calendar not, staff rarely offer activities, and she sits in her room often. On 3/16/22, at 8:53 a.m. licensed practical nurse (LPN)-F stated, there used to be an activity staff member who would come to the floor and do different group activities and one on one visits with the residents. LPN-F further stated, activities used to be good but it has been months since the activity department provided 1 on 1 visits for residents. R1 loves to keep busy, tries to talk with everyone, and wanders throughout the floor and that included going into other residents' room which increased the behaviors of the other residents and caused residents to strike out. LPN- F further stated the resident would mainly watch television for an activity. LPN-F stated the residents on 3 East need to have more consistent activities to help reduce the overall behaviors in the residents with traumatic brain injuries or dementia. R35's quarterly MDS dated 1/10/22, identified cognitively intact and a diagnosis of spina bifida. R35's MDS identified it was very important to listen to music, be around animals such as pets, participate in religious services and do favorite activities.	F 679		

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R35's care plan dated 2/2/22, indicated that she had a potential for an activity deficit and alteration in socialization due to being new to the facility, unfamiliar with routines and activities offered. She was to express satisfaction with independent leisure and activities of choice.

R35's Psychiatry Follow-up Note dated 2/04/22, recommended R35 participate in recreational activities for her psychiatric well-being.

When interviewed on 3/14/22, at 4:14 p.m. R35 stated she liked to watch TV and participate in bingo. Bingo was only offered once a week. All other activities were provided by the resident and her family. R35 stated she liked to make things with beads and complete puzzles. R35 also stated that she would like other activities, but none were offered.
R42's undated Admission Record indicated he had diagnoses that included non-traumatic intracerebral hemorrhage (bleeding into the brain) and hydrocephalus (buildup of fluid on the brain).

R42's quarterly MDS dated 1/28/22, identified severe cognitive impairment, with diagnosis of brain hemorrhage hydrocephalus (water on the brain), and a stroke. R42 was non-verbal and rarely/never understands verbal content.

R42's care plan revised on 11/10/21, revealed the resident had an alteration in supervised/organized recreation characterized by little or no involvement, lack of attendance related to aphasia (loss of ability to understand or express speech, caused by brain damage). Staff were to ensure resident is able to hear conversation and when attending activities; introduce resident to

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others sitting nearby at social events.

R42's document titled MISS-Activities Interview for Customary and Routine, dated 11/10/21,revealed resident was non-verbal and wouldn't respond to communication boards.

R42's progress notes revealed no activities documentation for the past 3 months.

Observation of R42 on 3/14/22, at 1:38 p.m. revealed the resident was lying in bed with his eyes open.

Observation of R42 on 3/14/22, at 5:17 p.m. revealed the resident was his geri chair in his room, with feeding pump running, no activities observed.

Observation of R42 on 3/17/22, at 1:48 p.m. revealed the resident was lying in his bed with his eyes closed, no activities observed.

Interview on 3/17/22, at 9:30 a.m. the activity director stated, they did not have an activities calendar and the care plans were not updated. She acknowledged that activities were not often done or offered to residents. The activities director stated the department was short staffed, and they, "have all been out ill recently."

On 3/16/22, at 1:02 p.m. director of nursing (DON) stated the facility had been short staff in a few departments which included activities so the residents had not been getting activities. DON stated residents should receive activities because it may help reduce behaviors especially for R1 who frequently wanders into residents' room. The DON further stated the activities would fall back

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onto the direct resident care staff who many times do not have enough time to complete the additional task. DON stated the residents on three East unit need to have consistent and structured activities which may help reduce behaviors from occurring which had occurred recently.

On 3/16/22, at 1:07 p.m. administrator stated the facility was short staffed in housekeeping and in activities department, and the nursing assistants or nurses should provide some actives to the residents throughout the day when not providing direct patient cares. She further stated the second and third floor East side residents did not get activities like they should and lacked for the past six months. The administrator stated the activities department needs to be revamped and residents need to have an appropriate activity assessment completed with person centered care plans which fits to individualized abilities.

On 3/17/22, at 9:30 a.m. activity director (AD) stated she had been out ill and unable to work recently and the activity department was short staffed. Additionally, the AD stated one of the other activity staff had been also out for 3 weeks due to an injury, which left one part-time staff person to complete activities for the facility. AD stated activities were just not getting done or offered to the residents. AD further stated there was no activity calendar being used or followed, if an activity was being held done on a day, staff would go around and invite residents to the activity. AD stated the activity assessment should be done upon admission and once a year or as the resident needed for each resident. AD further stated the resident's activity care plans had not been updated and activities were not provided

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F 679	Continued From page 12 very often because of the lack of staffing. Review of the facility's undated policy titled "Life Enrichment Policy" read, in pertinent part, "The activities department works seven days a week and has evening activities at least four times a week ...Activities are scheduled daily ...Activity calendar is posted in every residents room and in common community area's ...Individualized and group activities are provided ...Activity plans are reviewed quarterly ...A diversity of programs shall be offered in order to maintain the residents sense of purpose and self-respect." The facility policy Activity Evaluation revision date 6/18, indicated to promote the physical, mental, and psychosocial well-being of residents, an activity evaluation was conducted and maintained for each resident at least quarterly and with any change of condition that could affect their participation in planned activities. The policy further indicated the activity evaluation would be used to develop individual activities care plan to allow for the resident to participate in activities of their choice and interest.	F 679		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		4/27/22

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F 689	Continued From page 13 Based on observation, interview and document review, the facility failed to ensure the 2 east unit cleaning chemicals and sharps containers were secured away in a locked cabinet or cart, which had the potential to affect 8 of 19 residents who resided on the 2 East Unit and could access the shower room and utility room. Findings include: On 3/14/22, at 3:36 p.m. during observation a bottle of labeled Disinfecting Cleaner with Bleach was in the shower room door was unsecured and open. On 3/14/22, at 3:38 p.m. two sharps containers, and the bottles labeled Truekleen Clinging Toilet Bowl Cleaner, TruKleen Brev Blue Crème Cleanser, and Disinfecting Cleaner with Bleach were in the utility room located in hallway near resident rooms. On 3/14/22, at 5:18 p.m. during observation with director of respiratory therapy (DRT), DRT verified a three-quarter full bottle labeled Disinfecting Cleaner with Bleach was sitting in the shower room floor unsecured. DRT further verified two sharps' containers, and a half full bottle of Truekleen Clinging Toilet Bowl Cleaner, full bottle of TruKleen Brev Blue Crème Cleanser, three-quarter full bottle of Disinfecting Cleaner with Bleach were in the utility room. She further verified the door to the utility room fully open and unsecured. On 3/15/22, at 8:34 a.m. during observation two sharps' containers, and bottles labeled Truekleen Clinging Toilet Bowl Cleaner, TruKleen Brev Blue	F 689	F689 Free of Accident Hazards/Supervision/Devices " Lock on door to soiled utility room has been fixed the week of survey, chemicals removed from area in soiled utility room the week of survey. Chemicals in the shower room placed in locked cupboard to prevent any resident access the week of survey. " Audits to be completed daily by PM Shift Supervisor or designee to assure shower rooms are left in clean, satisfactory condition. To be continued until the QAPI team finds compliance is satisfactory or 100% compliance is met. " Education given to all staff with expectations of keeping all chemicals in locked cabinets when not in use. To be completed on or before 4/27/2022 by DON or Designee. " Education given to staff on proper disposal and storage of sharps containers. To be completed on or before 4/27/2022 by DON or Designee. " Education given to all staff with expectations of cleaning shower rooms and shower chairs after each use. To be completed on or before 4/27/2022 by DON or Designee. " Education given to all staff with expectations of utility room doors are to be closed and always locked. To be completed on or before 4/27/2022 by DON or Designee.	

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F 689	Continued From page 14	F 689		

Crème Cleanser, and Disinfecting Cleaner with Bleach remained in the unlocked dirty utility room. DRT removed the cleaners and stated maintenance needed to fix the lock.

On 3/14/22, at 4:00 p.m. nursing assistant (NA)-F, stated the chemicals should not be in the room where a resident can access them including the shower room or unlocked utility room.

On 3/14/22, at 4:03 p.m. registered nurse (RN)-A, stated the bleach cleaner should not have been left in the unsecured shower room on the floor and the cleaning chemicals in the dirty utility room should have been secured. He further stated 2 East had residents which are independently mobile once placed in a wheelchair and could have accidentally ingested the chemicals.

On 3/15/22, at 8:34 a.m. DRT stated chemicals should never be left in a shower room or an unsecured utility room because the residents could accidentally ingest the chemicals. DRT further stated the lock to the door had been broken for a while so staff were unable to secure it. She stated the chemicals should not have been left in the room.

On 3/16/22, at 1:10 p.m. the director of nursing (DON) stated her expectation would be all chemicals be stored properly per the storage guidelines. DON further stated chemicals are not to be stored in the bathroom or unlocked utility rooms because the risk for a resident accidentally ingesting or spilling chemicals on themselves. DON further stated the sharps containers are never supposed to unsecured and within reach of residents, because a resident could get a needle stick injury. The DON stated it was the

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responsibility of housekeeping to clean the shower room and properly store chemicals after they are done using them. She further stated her expectation of the 2 East staff were to immediately secure the chemicals and sharp containers once they were first notified on 3/14/22, by the surveyor.

On 3/16/22, at 1:00 p.m. administrator stated her expectation for staff was to never leave chemicals or sharp containers unsecured where residents may have access.

On 3/17/22 at 11:20 a.m. the maintenance director (MD) stated the door lock to the dirty utility room on 2 East was broken and was replaced. MD further stated chemicals or sharps containers should never be left in an unsecured cart or room and should have been removed immediately to avoid accident ingestion.

The facility's work order report from 9/1/21, to 3/17/22, lacked indication the lock on the utility room door was broken or required repair.

The facility's housekeeper checklist for two (2) West undated, indicated reminders to housekeeping staff to keep all chemicals away from residents and locked in a cart when not in use.

The TruKleen Clinging Toilet Bowl Cleaner Material Safety Data Sheet (MSDS) dated 4/15/15, indicated the Clinging Bowl Cleaner are solution was hazardous to a person's health. The MSDS indicated to avoid contact with eyes and skin. The MSDS further indicated the solution could cause chemical burns with prolonged contact.

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F 689	Continued From page 16 The TruKleen Brev Blue Crème Cleanser MSDS dated 4/9/15, indicated Brev Blue Crème Cleanser was hazardous to a person's health. The MSDS indicated to avoid contact with skin, eyes, or ingestion. The Procter and Gamble MSDS for Disinfecting Cleaner with Bleach dated 4/7/15, indicated the solution was hazardous to a person's health. The MSDS indicated to avoid contact with skin, eyes, clothing, or ingestion. The MSDS further to seek immediate medical attention if ingestion or eye or skin contact occurred. A facility policy was requested on chemical storage but was not received.	F 689		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		4/27/22

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F 693	Continued From page 17 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and policy review, the facility failed to ensure appropriate care of a gastrostomy (g-tube) during medication administration for for 3 of 3 residents (R42, R68, and R280) who were reviewed during medication administration. Findings include: R42's quarterly Minimum Data Set (MDS) dated 1/18/22, included severe cognitive impairment with diagnoses including malnutrition, dysphagia (difficulty swallowing) and aphasia (inability to speak). R42 received nutrition through a feeding tube. R42's Physician Orders included nothing by mouth and was to receive Glucerna via gastric tube (g-tube). Staff were to flush the g-tube every 4 hours and check placement of g-tube before start of feeing and every shift to ensure placement. R42 received several medications via g-tube. R42's care plan dated 10/26/21, identified a potential for altered nutrition and instructed staff provided the enteral nutrition and flushes as ordered. Medications were to be given per the feeding tube also. During observation on 3/14/22, at 7:26 p.m. licensed practical nurse (LPN)-B flushed R42's g-tube with 30 milliliters (ml) water and then	F 693	F693 Tube Feeding Management/Restore Eating Skills " R42 medication orders reviewed, ok to administer medication via cocktail order obtained from provider. Orders and Care plan updated. " R68 medication orders reviewed, ok to administer medication via cocktail order obtained from provider. Orders and Care plan updated. " R280□s medication orders reviewed, ok to administer medication via cocktail order obtained from provider. Orders and Care plan updated. " Review completed by Omnicare pharmacy consultant of all residents receiving medications via enteral feeding tube. Recommendations reviewed by provider, orders written for medications that are proper to be given as cocktail, orders and Care plans updated. " competencies to be completed with all nursing staff on proper administration of Enteral Feeding medications or starting enteral feedings, to include check placement of tube. " Ongoing audits of proper medication administration via enteral tube including check placement, checking orders, flushing before and after administration to be completed by Clinical Coordinator of each unit or designee until QAPI team	

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F 693	Continued From page 18 cocktailed several medications together, mixed them in water and pushed the medications in with the syringe. LPN-B did not check placement of tube in any manner and did not allow the medications to flow via gravity. LPN-B then flushed with another 60 ml water. The syringe was then placed in a graduated container that contained a small amount of water. When interviewed on 3/14/22, at 7:30 p.m. LPN-B stated he had mixed all of the medications together and pushed them in with the syringe. LPN-B stated nurses could push the medication in or allow it to flow in by gravity. LPN-B stated the syringe was always stored in the container with the leftover water and did not know of any policy directing otherwise. LPN-B stated he always mixed all of the medications together to administer them and was not aware of any policy indicating they should be separated and flushed in between them. R68's quarterly MDS dated 2/8/22, included moderate cognitive impairment and diagnoses including a traumatic brain injury, dysphagia and required a tube feeding. R68's physician orders for March 2022 included medications could be given orally mixed in applesauce or per g-tube, giving each medication separately and flushing between each medication. The flush was to be 60 ml before and after medication administration and 5 ml between each medication. The orders identified the placement of the g-tube needed to be checked every shift and prior to flushing or medications. R68's care plan dated 6/8/21, included the need for oral foods and nutrition through a feeding	F 693	finds compliance. " Education provided to all nursing staff to place open dates on syringe and place in plastic sleeve after each use, water to be disposed of after each medication pass. To be completed on or before 4/27/2022 by DON or Designee. " Audits to be completed on dating and storage of graduate cylinders and syringes 3x weekly until compliance is met. To be completed by DON or Designee. " Education to be completed with all nurses on cocktail medications, checking resident orders, gravity flow vs push of medications. To be completed on or before 4/27/2022 by DON or Designee. " Review of current medication administration policy to be completed by DON and QAPI team to assure accuracy of policy. Competed 4/18/2022 by DON	

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F 693	Continued From page 19 tube. When observed on 3/14/22, at 7:03 p.m. LPN-B crushed all medications together (including acetaminophen, a muscle relaxer, seizure medications, an antipsychotic, an antidepressant and a laxative) and placed them in water. LPN-B flushed the feeding tube with 60 ml water without checking for tube placement and pushed all the medication in via the syringe at once. LPN-B flushed the tube then placed the syringe into the graduate with leftover water in it. When interviewed on 3/14/22, at 7:23 p.m. LPN-B stated, he did not verify g-tube placement but should have and the facility's policy was to verify placement with air bolus and auscultation. LPN-B confirmed he crushed all medications together via push method and stated if there was no contraindication to giving medications together, he always crushed and administered medications at the same time. LPN-B confirmed R68's 60 cc syringe was undated and left in graduated container dated 3/14/22. LPN-B was not sure what the policy was for syringe storage and that staff always store the syringes in the graduated container with water. When interviewed on 3/15/22, at 1:50 p.m. LPN-D, who was the clinical supervisor, stated an order was required to "cocktail (crush and mix all together)" medications and it is a requirement to check placement of the g-tube prior to administration. In addition, the medications should have been administered separately with a 5 ml flush of water between each med and should have been allowed to flow by gravity instead of being pushed in with the syringe. The syringe and graduate should be dated and allowed to air dry	F 693		

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F 693	Continued From page 20 after use. Review of R280's undated Admission Record revealed R280 was admitted with diagnoses that included aphasia, protein-calorie malnutrition, and gastrostomy status. R280's Physician Orders included enteral feed Jevity 1.5 calorie BID via g-tube (enteral nutrition), Levaquin 500 mg tab via g-tube x 7 days for respiratory infection, and Sodium Chloride 3% vial via nebulizer TID (to maintain tracheal moisture). Review of R280's admission MDS dated 3/2/22 indicated it was not yet completed due to recent admission. R280's care plan dated 3/2/22, included, a tube feeding was required. During observation on 3/15/22, at 12:09 p.m. registered nurse (RN)-F administered medication via R280's feeding tube. RN-F flushed the tube and did not check tube placement. The syringe was returned to the graduate and placed in water. When interviewed on 3/15/22, at 12:10 p.m. RN-F stated she did not check placement of R280's g-tube prior to administration of medications, but should have. RN-F did not know the policy on storage of the syringe. When interviewed on 3/15/22, at 12:37 p.m. with RN-E stated the facility's g-tube policy included checking placement prior to medication administration, but if resident had a g-tube	F 693		

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F 693	Continued From page 21 feeding running, then they could directly administer medication without checking for placement; Nurses usually administer g-tube medications based on resident preference and noted some residents like medications administered by gravity, some like push method; if resident had a history of clogging, then they will do push method. When interviewed on 3/15/22, at 1:44 p.m. LPN-D stated the facility's g-tube medication administration policy was to check placement prior to administering medication and that nurses may administer medications via push method if needed, or by gravity and water flushes should be included in physician orders. When interviewed on 3/16/22, at 12:51 p.m. the director of nursing (DON) stated they did not have a policy on storing the syringe and graduate. However, syringes are changed every night and the graduate weekly. A facility policy titled Medication administration through and Enteral Tube, dated 12/11/19, directed staff to check g-tube placement prior to medication administration and to administer each medication separately, flushing between each, and to allow the medication and flush to flow in by gravity and not to push it in with the syringe.	F 693		
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	F 880		4/27/22

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F 880	Continued From page 22 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: (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.	F 880		

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F 880	Continued From page 23 (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 ensure all staff wore source control mask per CDC guidelines during the COVID-19 pandemic for 1 of 20 staff (NA-B) observed. Findings include: On 3/14/22, at 2:45 p.m. nursing assistant (NA)-B was observed to walk down the resident's hallway on two East and did not wear eye protection or her mask to cover her mouth and nose. On 3/14/22, at 4:00 p.m. NA-B was observed to walk out of a resident's room and down the hallway and had a mask on but it did not cover	F 880	F880 Infection Prevention and Control " Corrective action provided to agency staff (NA-B) for non-compliance with facility policy to always wear source control mask while in facility. "Staff Education to be completed with all staff on MDH (Minnesota Department of Health) requirements for Long Term Care facilities IC procedures. To be completed by infection Control Nurse or Designee to be completed on or before 4/27/2022 by DON or Designee. "Audits on proper Infection prevention/Control procedures to be completed 4x weekly times one week and then 2x weekly by Infection Control Nurse	

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F 880	Continued From page 24 her mouth and nose. On 3/14/22, at 4:03 p.m. during observation and interview registered nurse (RN)-A verified NA-B did not wear her mask. RN-A stated he had observed NA-B not wearing her mask or goggles many times before, "but you can only tell them so many times." On 3/15/22, at 9:30 a.m. NA-B was observed to come out of the shower room with a resident and her was mask under her chin. On 3/16/22, at 11:15 a.m. NA-B was observed to stand right outside a resident's door next to the director of respiratory therapy (DRT), within two feet from the resident, with her mask positioned under her chin. On 3/16/22, 12:45 p.m. NA-B was observed to exit a resident's room into the hallway and carried a lunch tray. NA-B was observed with her goggles on her forehead, and her mask positioned under her chin. During interview on 3/16/22, at 12:47 p.m. RN-E stated all staff are required to wear the appropriate personal protective equipment (PPE) when in contact or close contact of a resident which would include going into resident room and within the hallways. RN-E stated NA-B would provided education on PPE. During interview on 3/16/22, at 1:00 p.m. director of nursing stated staff were required to follow the guidelines regarding PPE which included wearing a mask and eye protection. DON further stated her expectation for staff to wear the PPE required, but also wear it appropriately which	F 880	or Designee. To be continued until 100% compliance is met or decided by QAPI team.	

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F 880	Continued From page 25 means mask must be worn over the nose and mouth. During interview on 3/17/22, at 11: 52 a.m. RN-C stated the facility had just gotten out of an outbreak status for COVID-19, and it was important for staff to wear the appropriate PPE as directed in the education provided on infection control. RN-E further stated during the COVID-19 outbreak that recently occurred was related to staff and residents not following PPE and maintaining appropriate distance. The current Center for Disease Control (CDC) guidance last updated on 2/2/22, indicated all health care workers are required to wear a well fitting surgical mask for source control at all times in nursing homes. The mask must be well fitted and cover both mouth and nose.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the 3 East hallway carpets were kept clean, sanitary and in good repair, which had the potential to affect all residents who resided on 3 East Unit. The facility failed to ensure the shared bathroom/shower and lounge on the 2 East Unit, were maintained in good repair and in a clean manner. In addition, the facility failed to ensure the only working elevator in the facility was kept clean and	F 921	F921 Safe/Functional/Sanitary/Comfortable Environment " Elevator cleaned and free of debris and walls cleaned on 3/17/2022 " carpets shampooed on 3 East unit 3/29/22 and 4/18/22. " 2 East Shower room and shower chairs cleaned 3/14/2022 . " Audits of elevator cleanliness are to be	4/27/22

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F 921	Continued From page 26 sanitary, which had potential to affect all residents, visitors, and staff who used the elevator. Finding include: During observation on 3/14/22, at 11:30 a.m. the only facility elevator was found to have dirty walls, doors, floor, and buttons that were covered with dirt, grime, dried food, and streaks of dried thick white substance. Grease and dirt were streaked across the button panel on the elevator. During observation on 3/14/22, at 12:41 p.m. the 3 East unit had an overwhelming odor of urine that permeated the unit. All the carpet was stained with a foot diameter brown, black, and red color spots throughout the hallways with scattered pieces of crumpled up brown paper towels, ripped pieces of paper, and medical gloves. During observation on 3/14/22, at 1:26 p.m. the 2 East shower room door was open. The floor had a dry, brown stained area that covered 40 percent of the shower room floor and was littered with paper towels and dirt. Two shower chairs in the shower room had dry stool splattered and smeared on the seats. Inside the sink in the shower room was a dirty glove with a four-inch piece of clear medical tape and a quarter size stain of blood. To the left side near the wall was a pile of dirty stained laundry that sat directly on the floor, which consisted of two bath towels, one hand towel, a hospital gown, a black t-shirt, and socks. To the right side of the room on the floor were two dirty brown stained washcloths and a hand towel, that sat directly on the ground. In addition a garbage can was overflowing with paper towels, gloves, and used incontinent	F 921	completed by Maintenance Director or Designee daily until determined satisfactory by QAPI team. " Audits of shower rooms to be completed daily by PM supervisor or Designee until determined satisfactory by QAPI team. " 3E carpets to be cleaned weekly until able to be replaced	

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F 921	Continued From page 27 products. During observation on 3/14/22, at 2:16 p.m. the 2 East resident lounge was found to have a bariatric shower chair which was placed next to the left side of the wall, that was stained with a four inch long by three-inch wide, dried smear of stool that was splattered on the seat. The shower chair was located four feet across from a microwave. During observation on 3/15/22, at 7:00 a.m. the only facility elevator continued to have dirty walls, doors, floor, and buttons that were covered in dirt. In the corner of the elevator was a used rolled up glove and paper towel. During observation on 3/16/22, at 10:10 a.m. the 2 East shower room door was opened, the floor was wet, there were three-to-two-inch spots of brown stool that were one and a half foot away from the shower drain. A plastic bag on the floor near the sink, contained a stool filled brief that sat on the floor. In the sink was a dirty glove and blood-stained clear medical tape. Just outside the shower room on the floor was a 50-cent piece size of stool. During observation on 3/16/22, at 12:30 p.m. the elevator was found to be dirty with the walls, doors, floor, and buttons were covered with dirt. On 3/14/22, at 2:30 p.m. registered nurse (RN)-A verified the shower room contained dirty laundry on the floor, stool on both shower chairs, the floors were stained and littered with garbage. RN-A stated the shower chair that was placed in the resident lounge area should never have been left soiled with stool in a common area were	F 921		

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F 921	Continued From page 28	F 921		

residents have visitors. RN-A further stated it was the responsibility of the nursing assistant (NA) to clean up the shower room after each use and ensure patient care equipment was cleaned and sanitized, ready for the next resident.

On 3/14/22, at 3:00 p.m. director of respiratory therapy (DRT), who was the manager of the unit that day, stated, the shower rooms should never be left dirty with garbage and laundry on the floor, stool on the shower chairs, or the floor covered in dirt and stains. DRT stated the facility had been short staff with housekeeping and the unit did not get cleaned like it should. DRT further stated her expectation would be for staff to clean and sanitize the shower room, take out the garbage, and remove the linens so it was ready for the next resident.

On 3/16/22, at 8:30 a.m. licensed practical nurse (LPN)-F stated the reason why the carpet was filthy and contained a strong smell of urine was due to a previous resident who would wander throughout the halls and urinate and defecate on the carpet. LPN-F further stated she reported the concerns of the carpet to an unknown person in the maintenance department.

On 3/16/22, at 10:15 a.m. RN-E stated, the nursing assistants just gave a resident a shower, but the stool on the floor before you enter the shower room should have been cleaned up. RN-E further stated if the nursing assistants were busy providing care for the resident, they should have at least shut the door to the shower room until they had time to clean up the 3 spots of stools or at least asked another staff person to help clean up. RN-E stated that was an infection control issue.

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F 921	Continued From page 29 On 3/16/22, at 10:43 a.m. the director of nursing (DON) stated the facility was short staffed with housekeeping staff so the staff nursing staff do what they can do and then it falls back on the floor staff to assist and clean things as they come up. She further stated the carpet on 3 East unit had been dirty and odorous for a while and maintenance tried to get it replaced. DON stated she had heard about the shower chairs on 2 East that were soiled with stool and the stool found outside the shower room on the floor on nursing unit and lounge and staff should have shut the door to the shower room until they were able to clean it up. She further stated random audits on each unit had been recently implemented to assess for odors, insects, curtains, and ceiling tiles, with the hope the staff would be aware of the needed work and report any observed concerns to maintenance to be addressed. On 3/17/22, at 1:10 p.m. the administrator stated the facility had areas which were dirty and need to be cleaned but there was only so much that could be done with being short staffed. She further stated the elevator should be cleaned by housekeeping daily and as needed. The administrator stated the carpets on 3 East needed to be replaced but getting the funding from the owner had been difficult. On 3/17/22, at 10:59 a.m. during the environmental tour of the facility the maintenance director (MD) verified the 3 East unit's carpet which was 75 percent stained dark and had a significant urine odor which permeated the unit. MD stated, the carpet had been cleaned recently, and the carpet was old, there was no fixing it and all the carpet needed to be "removed and	F 921		

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F 921	Continued From page 30 replaced." He further stated a previous resident would urinate and defecate on the carpet throughout the 3 East unit and the residents were at risk for infection due to bacteria spreading from the carpet. MD estimated the north hallway carpet to be 115 feet long by 12 feet wide. The east hallway estimated to be about 100 feet long by 12 feet wide. The 3 East day room measured 15 feet long by 30 ft wide and the end of the hall opened area measured 60 feet long by 12 feet wide. He further stated the carpet was supposed to be replaced in September of 2021, but another issue came up and needed to be repair. Also, MD stated they did not have enough staff to help complete all the necessary cleaning throughout the facility like the elevator, which he stated was a big infection control issue and people were going to get sick. The facility maintenance request logs dated 9/21/21, to 3/7/22, lacked indication work orders were placed for the carpet on 3 East unit. The facility untitled form dated 3/15/22, indicated a description of tasks for each housekeeper to complete throughout the day. The form further indicated at the end of the day to identify and fix spills, odors, debris, in residents' room, bathrooms, and nursing rooms. A facility policy related to providing a homelike environment and/or control of odors was requested but was not provided by the facility.	F 921		
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side.	F 924		4/27/22

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F 924	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure all handrails were firmly secured to walls in 1 of 2 units. This had the potential to affect R1 and other residents on three (3) East Unit who were ambulatory and/or in a wheelchair who used the handrails. Findings include: R1's admission minimum data set (MDS) dated 9/8/21, indicated R1 had a traumatic brain dysfunction (TBI), a history of falling, and lacked coordination. R1's care plan (CP) dated 3/17/22, indicated R1 was independent with mobility. R1's progress note (PN) dated 3/6/22, indicated R1 was unstable on her feet and walking appeared to be difficult. On 3/14/22, at 4:15 p.m. during observation on the 3 East unit, R1 was observed to walk with a shuffled gait, up and down the unit halls and used the handrails to balance herself at times. R1 grabbed the handrail that was at the end of the east hall on the left side, the handrail was observed to be loose and moved with pressure. When surveyor assessed and touched the handrail, the screw on the right end was observed to be loose and not securely adhered to the wall for stability. On 3/14/22, at 4:30 p.m. during observation of the 3 East unit hallway, across from the last room on the left-hand side near room 3001, six feet of the handrail was missing completely off the wall and	F 924	F924 Corridors have firmly Secured Handrails " Handrails on 3 East were fixed and secured on 3/17/2022. " Audits of handrails throughout the facility will be conducted by Maintenance Director or Designee weekly until determined satisfactory by QAPI team. " Education provided to staff to place all safety concerns into facility TELs reporting system to notify maintenance of needed repairs promptly. Education to be completed by Staff Development Director on or before 4/27/2022.	

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F 924	Continued From page 32 only the holes where the anchors came out remained. On 3/15/22, at 11:45 a.m. licensed practical nurse (LPN)-F verified the handrails was missing and the other handrail was loose. LPN-F stated she had not reported the handrails to the maintenance department. On 3/17/22, at 10:59 a.m. the director of maintenance (DM) verified the handrail was loose and the other handrail was missing. He further stated the maintenance department was responsible to check the handrails, and replace the handrails as needed. The DM stated he does a daily walk through of the facility and was unsure of how long the railing had been missing. On 3/17/22, at 1:10 p.m. the administrator stated all handrails were supposed to be firmly affixed to the wall as multiple residents on the unit used them and the loose and missing handrails could be a safety hazard. Review of the facility maintenance log request lacked indication a work order was placed to fix handrails. Request for facility policy on handrails was requested and not provided.	F 924		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/16/2022. At the time of this survey, BAY VIEW NURSING HOME AND REHABILITATION 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 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 detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. BAY VIEW NURSING HOME AND REHABILITATION CENTER is a three-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, an addition was constructed to the West Wing that was determined to be of Type II (222) construction. In	K 000		

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K 000	Continued From page 2 1999 a small addition was constructed to the West Wing. Because the original building and the (2) additions meet the construction types allowed for existing buildings, those portions of the facility were surveyed as one building. A full fire sprinkler system protects the building. In addition, 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. The facility has a capacity of 110 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to test emergency egress lighting devices in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1, 7.9.2.1, and 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 03/16/2022, between 09:00 AM to 03:00	K 291	K291 1.Ewgress lighting found in non-compliance was corrected on or before 04/01/2022. An Audit of all facility egress lighting will be completed on or prior to 04/25/2022. 2.Standard testing of all facility egress lighting will be completed monthly with an minimum of once annual 90-minute testing. 3.Maintenance Director will monitor to ensure compliance is maintained.	4/25/22

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K 291	Continued From page 3 PM, it was revealed by a review of available documentation that no evidence was presented for review to confirm that an annual 90 minute testing of emergency light fixtures had been completed. 2. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that the emergency egress light located on the 3rd floor in the Physical Therapy Area did not function properly upon testing. 3. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that the emergency egress light located on the 2nd floor in the Staff Lounge corridor did not function properly upon testing. 4. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that the emergency egress light located on the 1st floor in the Staff Office Area corridor did not function properly upon testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	4.Maintenance Director is responsible for compliance. 5.Date completed: 4/25/2022	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited	K 324		4/26/22

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K 324	Continued From page 4 cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review, and staff interview, the facility failed to provide documentation that the commercial kitchen fire extinguishing equipment was being tested and maintained in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5, 9.2.3, NFPA 96 (2012 edition) Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2, and NFPA 17A (2009 edition) Standard for Wet Chemical Extinguishing Systems, section 7.5. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: 1. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by a review of available documentation that no evidence was available or	K 324	K324 1.The commercial kitchen fire extinguishing equipment was tested on 1/24/2022. Kitchen fire suppression system will be replaced on 4/26/2022. 2.Testing of the commercial kitchen fire extinguishing equipment will be conducted bi-annually. 3.Maintenance Director and/or designee will monitor to ensure compliance is maintained. 4.Maintenance Director is responsible for compliance. 5.Date completed: 4/26/2022	

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K 324	Continued From page 5 presented for review to confirm that the six-month required interval inspection of the Ansul type fire extinguishing equipment system had been completed. 2. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by a review of available documentation that the documentation presented for review identified that the most recent 12-year hydro test of the Ansul type fire extinguishing equipment system was completed in 2008. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324		
K 345 SS=F	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 a review of available documentation and staff interview, the facility failed to maintain and test the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 19.3.4 and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, section 17.2, 17.14.3, and 17.14.5. This deficient finding could have a widespread impact on the residents within the facility.	K 345	K345 1.Furniture blocking the fire alarm pull station was moved immediately. The dislodged fire alarm tamper cover was replaced on 03/17/2022. 2.Staff was educated on maintaining a clear path to fire alarm pull stations and systems as well as identifying any hazards preventing proper operation of fire alarm	4/22/22

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K 345	Continued From page 6 Findings include: 1. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that on the 3rd floor, in the Memory Care Unit, a fire alarm pull-station access was physically obstructed by furniture. 2. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that on the 3rd floor, in the Memory Care Unit, a fire alarm pull-station protective/tamper cover was dislodged from its anchoring to the wall, thus impeding the proper operation of the cover and immediate access to the pull-station An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	systems the TBI unit by the Maintenance Department on 3/16/2022. Remaining staff will be completed on or before 4/22/2022. 3.Maintenance Director and/or designee will monitor clear path and operability of fire alarm pull stations and systems to ensure compliance is maintained by completing rounds on all units weekly. 4.Maintenance Director is responsible for compliance. 5.Date Completed: 4/22/2022	
K 353 SS=F	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 _____	K 353		4/22/22

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K 353	Continued From page 7 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, a review of available documentation, and staff interview, the facility failed to inspect and maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2 and 5.2.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that fire sprinkler quarterly inspections are being completed for the sprinkler system. 2. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that sprinkler heads exhibited signs of oxidation and paint splatter on the 2nd floor in the 2 West corridor - Shower Room. 3. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that sprinkler heads exhibited signs of oxidation on the 1st floor in the Kitchen Dishwashing area. An interview with the Maintenance Director verified this deficient finding at the time of	K 353	K353 1.The sprinkler system, including all sprinkler heads were visually inspected. Sprinkler heads impacted by paint overspray will be replaced on or prior to 04/01/2022. 2.Testing was completed on 5/13/2021 and will be reinspected 5/22/2022 3.Maintenance Director and/or designee will keep appropriate, available records with pertinent information to include the date of last inspection, who inspected the system and the water system supply source, to maintain compliance. Summit has been instructed to do quarterly as well as annual inspections. 4.Maintenance Director is responsible for compliance. 5.Date Completed: 4/22/2022	

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K 353	Continued From page 8 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 the accessibility of portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that on the 2nd floor near the entrance of the facility, that access to the fire extinguisher was obstructed by a temperature scanning device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	K355 1.The fire extinguisher was blocked by the Covid-19 Monitoring system. This was corrected 3/16/2022. 2.Rounding will be completed bi-monthly to determine that all fire extinguishers are free from barriers to access by Maintenance Director and/or designee. 3.Maintenance Director is responsible for compliance. 4.Date Completed: 03/16/2022	3/16/22
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		4/22/22

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K 363	Continued From page 9 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections	K 363	K363 1.Door closures were replaced as needed on 4/15/2022.	

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K 363	Continued From page 10 19.2.2.2, 19.3.6.3.5, 4.6.12, 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that upon testing the 3rd-floor fire doors, they did not self-close, sealing the opening. 2. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that upon testing the 1st floor - Kitchen Dishwashing fire doors, they did not self-close, sealing the opening. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 363	2.All doors have been inspected for appropriate closure time. 3.Rounding will be completed monthly by Maintenance Director and/or designee to continue compliance. 4.Maintenance Director is responsible for compliance. 5.Date completed: 4/22/2022	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.	K 374		4/26/22

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K 374	Continued From page 11 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that upon testing of the 3rd-floor smoke barrier door assemblies, they exhibited an air gap greater than 1/8 inch. 2. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that upon testing of the 2nd-floor smoke barrier door assemblies, they exhibited an air gap greater than 1/8 inch. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 374	K374 1.Contractor is scheduled to address gaps on all smoke barrier doors on 4/26/2022. 2.Contractor will make necessary adjustments to maintain compliance. 3.Maintenance Director and/or designee will round monthly to determine the smoke barrier doors have an air gap of less than 1/8 inch. 4.Maintenance Director is responsible for compliance. 5.Date Completed: 4/26/2022	
K 712 SS=C	Fire Drills 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	K 712		4/19/22

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K 712	Continued From page 12 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 a review of the available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4, 19.7.1.6, 4.7.2, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that a fire drill had been conducted for the 2nd quarter 2021 - 2nd shift. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	K712 1.Fire drill was conducted on 2nd shift on 4/14/2022. 2.Maintenance Director and/or designee will complete fire drills per the Life Safety Code Rules. 3.Maintenance Director will determine compliance based on monthly reviews of past and future fire drills. New forms and education was given by the Fire Marshal on 4/19/2022 to be used for future drills 4.Maintenance Director is responsible for compliance. 5.Date Completed: 4/19/2022	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line	K 914		4/22/22

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K 914	Continued From page 13 isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.1.4, 6.3.4.2.1.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by a review of available documentation that the documentation presented for review did not identify or provide confirmation that the physical condition, ground continuity, polarity, and ground retention force of the individual outlets in resident rooms had been completed. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 914	K914 1.All receptacles will be tested in patient care rooms for ground continuity, polarity, and ground retention force on or before 4/22/2022. New forms and education was provided by the Fire Marshal on 4/19/2022. 2.Maintenance Director and/or designee will schedule annual testing of all facility outlets. 3.Maintenance Director is responsible for compliance. 4.Date Completed: 4/22/2022	
K 920 SS=E	Electrical Equipment - Power Cords and Extens	K 920		3/16/22

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K 920	Continued From page 14 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 employ relocatable power taps per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D), and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 920	K920 1.All daisy-chained power strips are no longer being utilized. 2.Medical grade power strips have been purchased and put in use. 3.Maintenance Director and/or designee will complete rounding to assure compliance on a monthly basis. 4.Maintenance Director is responsible for compliance. 5.Date Completed: 3/16/2022	

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K 920	Continued From page 15 1. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that on the 1st floor in the Education Office that daisy-chained power strips were in use 2. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that on the 1st floor in RM 1-098, daisy-chained power strips were in use. 3. On 03/16/2022, between 09:00 AM to 03:00 PM, it was revealed by observation that an appliance was connected to a power strip on the 3rd floor in the Admin Office. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920		