Electronically delivered
July 19, 2019

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

RE: Project Numbers H5223152C, H5223155C

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

Dear Administrator:

On June 27, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 26, 2019.

Also on June 27, 2019, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy(ies):

- Civil money penalty. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on June 7, 2019. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On July 16, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on June 7, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 3, 2019. We have determined, based on our visit, that your facility has corrected as of July 7, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 26, 2019 be rescinded as of July 7, 2019. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 27, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 7, 2019.

In addition, this Department recommended to the CMS Region V Office the following the remedies:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

July 19, 2019

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

Re: Reinspection Results - Complaint Numbers H5223152C, H5223155C

Dear Ms. Pierzina:

On July 16, 2019 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on June 7, 2019. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

Electronically Submitted
June 27, 2019

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

RE: Project Numbers H5223152C, H5223155C, H5223151C, H5223149C, H5223148C, H5223150C, H5223153C, H5223154C

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

Dear Administrator:

On June 7, 2019, an extended survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

In addition, at the time of the June 7, 2019 the extended survey the Minnesota Department of Health completed an investigation of complaint number Numbers H5223152C, H5223155C which were found to be substantiated and H5223151C, H5223149C, H5223148C, H5223150C, H5223153C, H5223154C which were found to be unsubstantiated.

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

## REMOVAL OF IMMEDIATE JEOPARDY

On June 5, 2019, the situation of immediate jeopardy to potential health and safety cited at F389 was removed. However, continued non-compliance remains at the lower scope and severity of D.

## REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 26, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 26, 2019,(42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 26, 2019,(42 CFR 488.417 (b)).

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

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 7, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bay View Nursing & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 7, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

## APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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

Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245223 | A. BUILDING _____ B. WING _____ | C 06/07/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BAY VIEW NURSING & REHABILITATION CENTER** | **1412 WEST FOURTH STREET RED WING, MN 55066** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS | F 000 | | |

On 6/3/19 through 6/7/2019, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.

An IJ was identified under Quality of Care at F689. As a result an extended survey was completed.

The IJ began on 6/3/19, following an elopement from the facility while R1 was intoxicated. On 6/4/19, at 5:15 p.m. the facility owner, administrator, and director of nursing were informed of the IJ. The IJ was removed on 6/5/19, at 4:33 p.m. when it could be verified by observation, document review and staff interview, the facility had implemented an approved removal plan.

The following complaint H5223155C was found to be substantiated with deficiency cited at F689 and F740.

The following complaint H5223152C was found to be substantiated with no deficiency cited.

The following complaints H5223151C, H5223149C, H5223148C, H5223150C, H5223153C, H5223154C were unsubstantiated.

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/07/2019 |

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

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| F 000 | Continued From page 1<br>be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to identify, complete assessment, implement interventions and provide supervision for 1 of 1 resident (R1) who consumed alcohol and eloped from the facility. This failure resulted in an immediate jeopardy (IJ) for R1.<br><br>The IJ began on 6/3/19, following an elopement from the facility while R1 was intoxicated. On 6/4/19, at 5:15 p.m. the facility owner, administrator, and director of nursing were informed of the IJ. The IJ was removed on 6/5/19, at 4:33 p.m. however, noncompliance remained at a scope and severity of a D.<br><br>Findings include:<br><br>R1's neuropsychiatric visit note dated 12/12/18, | F 689 | R1 WAS FOUND AND BROUGHT TO THE HOSPITAL FOR ASSESSMENT. NO INTERNAL OR EXTERNAL INJURIES FROM EVENT. R1'S CAREPLAN REVIEWED AND REVISED. ACCUTEK APPLIED UPON RETURN. ACCUTEK SYSTEM SECURES THE ELEVATORS AND 3 EAST ENTRANCE.<br><br>ALL RESIDENTS HAD THE NEW ELOPEMENT ASSESSMENT COMPLETED ON 6/5/2019.<br><br>IMPLEMENTATION OF THE ELOPEMENT BINDER INCLUDING: POLICY ON ELOPEMENT RISK, POLICY ON MISSING RESIDENT, CHECKLIST, ELOPEMENT ASSESSMENT, SEARCH | 7/3/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 689 | Continued From page 2<br>identified R1's medical history included a traumatic brain injury (TBI) as a result of R1 having been hit by a car when walking along a highway intoxicated. The neuropsychiatric exam indicated R1's IQ score was between 75 and 87, and indicated R1 had reduced safety awareness. In addition, the note included, "He requires a court-ordered guardian to assist him in making healthcare and financial decisions due to severe cognitive impairment." The note also indicated R1 would likely require 24 hour supervision once he returned to the community.<br><br>R1's Admission Record included diagnoses of diffuse traumatic brain injury, alcohol abuse, and anxiety disorder.<br><br>R1's quarterly Minimum Data Set (MDS) assessment dated 3/29/19, indicated R1 was independent with transfers, was independent with ambulation on and off the units, and required supervision with hygiene. The MDS also indicated R1 exhibited rejection of care behaviors 1-3 days during the assessment period.<br><br>R1's Care Area Assessment (CAA) for Behavioral symptoms and Cognitive Loss/Dementia dated 10/18/18, were triggered to be completed by the admission MDS. The Behavioral assessment was not completed, however identified R1 to have a head injury, pain, and verbal behaviors directed at others. The Cognitive Loss CAA was also not completed, however indicated this CAA was triggered because of diagnosis of TBI, assessed mood state, behavioral symptoms, and presence of pain coded on the MDS during the assessment period.<br><br>R1's current care plan provided on 6/6/19, | F 689 | LOG, LIST OF CODES, AND SKIN ASSESSMENT ON 6/4/2019.<br><br>PICTURE OF EACH RESIDENT WITH ELOPEMENT RISK IN eLOPEMENT BINDERS AT EACH UNIT AND AT RECEPTION DESK.<br><br>EDUCATION WAS PROVIDED TO ALL STAFF PERTAINING TO EXPECTATION FOR ELOPEMENT/ELOPEMENT BINDER STARTING 6/4/2019. REVIEW EDUCATION WILL BE COMPLETED AT JULY MONTHLY MEETINGS.<br><br>ELOPEMENT DRILL COMPLETED ON 6/10/2019 AND WILL BE COMPLETED ONCE A MONTH FOR 4 MONTHS.<br><br>OUTCOME WILL BE OBSERVED AT QAPI. THE DIRECTOR OF NURSING OR DESIGNEE WILL BE RESPONSIBLE FOR COMPLIANCE BY JULY 5, 2019. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 689 | Continued From page 3 | F 689 | | |

indicated R1 was independent with ambulation, transfers, and toileting. The care plan also indicated R1 had cognitive impairment related to TBI. The goals directed staff to anticipate his needs, and staff along with guardian to assist in decision-making. The care plan for elopement risk initiated 10/18/18, indicated R1 was at risk for elopement related to "making statements as wanting to leave, sufficient mobility to exit unescorted loitering near exits; unawareness of need for care/supervision due to cognitive and emotional symptoms". The associated interventions directed staff to apply Wanderguard and Accutech on left wrist. The care plan also indicated a trial removal of the devices was conducted however, R1 eloped from the facility on 12/17/18, with the intention of walking to Bemidji, Minnesota.

During the facility tour, the facility was observed to have 3 floors with resident elevators that were not secured. In addition, the facility was also observed to be divided into separate nursing units. The facility exits were observed to have a Wanderguard System. The system was identified to use battery operated bracelets applied to residents who were determined to be at risk for elopement. The bracelets omit radio waves, which sounds an audible alarm if the bracelet is in near proximity to an exit. The system did not prevent residents from exiting the building. The third floor had a semi-secured unit which utilized an Accutech system. Upon review, the Accutech system was similar to the Wanderguard system however, the Accutech system automatically locked the unit doors from both sides when a resident was near the unit exit doors. The Accutech system was only utilized on the exit doors to the third floor unit but nowhere else in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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the facility. R1 resided on the 3rd floor semi-secured unit.

R1's Elopement Risk Assessment dated 12/10/18, indicated since R1 did not have a history of elopement attempts, and hadn't demonstrated current elopement behaviors, the Wanderguard and Accutech were removed.

R1's progress note dated 12/17/18, at 8:15 a.m. indicated R1 was spotted walking west on highway 61, the administrator was notified, and 911 was called. That same day at 10:38 a.m., a progress note indicated the police had still not found R1. The note further indicated events prior to R1 being found on the highway included: R1 had told staff he was going to go smoke outside and when nurse went to give R1 medications, R1 was not found and a facility wide search was initiated. At 12:24 p.m. on 12/17/18, the progress note indicated the police had returned R1 to the facility at 11:45 a.m. A subsequent progress note documented 12/17/18 at 1:36 p.m., indicated R1 had again left the facility however, a staff member was following him, and R1 was returned to the facility with the help of the police. The progress note dated 12/17/18 at 3:34 p.m., indicated staff had placed a Wanderguard on R1's left wrist. However, the Accutech system was not put in place.

R1's physician progress note dated 2/12/19, included: "He [R1] continues to have severe cognitive deficits and physical limitations, has reduced safety awareness and will likely require 24 hour supervision when he is ready to discharge from the facility. Neuro-psych testing confirmed this, and advised for a guardian." The note also indicated R1 was unaware of deficits,

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had poor judgment, and requested to go home.

R1's physician progress note dated 3/22/19, indicated the evaluations from the physician visit 2/12/19, and now included, "Patient has used alcohol regularly," and was insistent he needed to go home.

R1's progress note dated 3/22/19, indicated R1 did not need to be escorted off the semi-secured unit and was allowed to go out to the secured courtyard to smoke on his own.

R1's Elopement Risk Assessment dated 3/29/19, included R1 was at risk for elopement. The assessment indicated after the Accutech and Wanderguard had been removed, R1 had walked out/eloped from the facility on 12/17/18, in an effort to return home, which placed R1 in harm's way because he walked on a highway, and attempted to hitchhike. The assessment indicated R1 had talked about leaving the facility to go home. The environmental risk section indicated the facility was near a busy street near woods and hills, and indicated water was on the grounds.

R1's social services progress note dated 4/9/19 at 12:18 p.m. included, "Resident let writer know he plans on leaving AMA tomorrow (4/10/19) at 0500 [5:00 a.m.]. His plans are to get to the bus station "in the cities" and take that to Bemidji. It was explained to him that this facility is not able to send meds or prescriptions with him."

R1's record lacked evidence R1's family members and the physician were notified of R1's plan to leave the facility.

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R1's progress note dated 4/10/19, at 10:38 a.m. included, "Resident left facility on AMA at 0950 (9:50 a.m.)." The record indicated even though R1 had significant cognitive impairment and required 24-hour supervision, the facility provided R1 a form to make the medical decision to leave the facility AMA to which R1 signed the form and left the facility. (According to the National Weather Service records, on 4/10/19, the high temperature was 36 degrees with a low of 34 degrees).

The Facility Release for Responsibility For Discharge form dated 4/10/19, at 9:40 a.m. included, "This is to certify that I, [resident name], a resident at Bayview Nursing and Rehab, am leaving against the advice of the attending physician [physician name], and of the nursing home administration, and absolve the management of the said care facility, it's personnel and the attending physician of responsibility for any ill effects or any deterioration in condition, or accident which may result from such." The form was signed by R1 and licensed practical nurse (LPN)-A.

R1's progress notes indicated on 4/10/19 at 1:23 p.m., a family member was notified (nearly 3.5 hours after R1 had left the facility AMA), R1 had left AMA. The notes indicated R1 had subsequently called the facility, time of call was not documented, informing staff he was at the hospital drinking coffee. A note at 2:35 p.m., indicated a different family member had called inquiring why the facility had allowed R1 to leave the facility. The progress note indicated it was explained to the family member the facility had explained the risks and benefits to R1 about leaving, and R1 had still made the decision to

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leave. The note then indicated the facility had previously been unaware a court had awarded emergency guardianship to the family, and did not have record of the court ordered judgment, which was then provided to the facility. The court guardianship document dated 1/31/19, indicated emergency guardianship was granted to family members as of that date because R1 could not manage his own care and could not make his own decisions.

A progress note dated 4/10/19 at 5:49 p.m., indicated the resident was returned to the facility by the police 8 hours after he'd left the facility. The note also indicated upon R1's return, a Wanderguard device was applied to his left wrist.

R1's elopement care plan had an intervention added 4/16/19, that directed staff to immediately call the police department if R1 left the facility.

R1's physician visit notes from a 4/22/19 visit, included the aforementioned evaluations from the physician's visit 3/22/19, and indicated R1 continued to utilize alcohol and insist on returning home.

R1's progress note dated 5/5/19, at 1:27 a.m. indicated R1 had been observed on the 1st floor nursing unit at 10:15 p.m. with an unsteady gait, slurred speech, and a cup of juice that smelled like Vodka. The note indicated R1 was assisted to bed. A progress note dated 5/23/19, indicated R1 had been drinking alcohol several times over the weekend.

R1's physician visit note dated 5/14/19, continued to reflect R1's persistent alcohol use and insistence to return home.

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R1's progress notes from 5/23/19, at 6:11 p.m. indicated R1 had pain in his right shoulder and was sent to the emergency room for further evaluation.. The note indicated R1 had returned at 2:27 a.m. on 5/24/19.

A progress note dated 5/30/19, at 4:01 p.m. included "Resident stated the ER cut off his Wanderguard. New Wanderguard placed."

R1's treatment administration record (TAR) directed staff to check Wanderguard placement every shift and directed the night shift staff to check placement and function. The TAR had checked marked boxes with initials that indicated the Wanderguard was checked for placement and function as directed on all days and shifts between 5/24/19, and 5/30/19, even though the Wanderguard had been removed in the emergency room 5/23/19.

A progress note dated 6/1/19, at 10:22 p.m. indicated R1 was on the 2nd floor of facility, drunk, laying on the floor of another resident's room. The note indicated R1 had refused to go upstairs to his unit so the police were called. Further, the note indicated R1 became physically aggressive with the officer, and was escorted out of the facility by the officer. R1 returned to the facility on 6/2/19, at 7:30 a.m.

An emergency room visit note dated 6/1/19, indicated R1 had a history of cognitive disorder related to TBI and had presented to the emergency room via police for evaluation of alcohol intoxication. The note included: "The patient states he has consumed a gallon of vodka tonight and was a common occurrence for him".

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The note also indicated the police department reported that the patient (R1) had been consistently consuming alcohol for the past six weeks but they were unsure how he was obtaining it. The visit note also included R1's blood alcohol level was high.The note indicated R1 was discharged back to the facility for monitoring with no new orders.

R1's Incident Report note dated 6/3/19, at 9:23 p.m. indicated R1 was reported to be under the influence of alcohol, continued to drink, left the facility and was picked up by the police, and was taken to the emergency room with no injuries. The report indicated at 9:50 p.m., the physician was contacted in regards to R1 leaving the facility, and the interdisciplinary team had made the decision to re-implement the Accutech system until the family responded to phone calls.

R1's progress note dated 6/3/19, at 11:39 p.m. indicated R1 had accidently gone out the wrong door to smoke, staff had seen this happen and brought R1 to the right area. The note indicated the family was contacted with a request to activate the Accutech system, and the MD had given orders to hold risk medications. The note furhter included, "Police officer called the facility stating that our resident was found downtown and they were bringing him to the hospital. Officer stated that the resident was found down by main street acting disorderly. The police officer went to approach the resident but resident acted like he might get aggressive. The resident was handcuffed and driven to the ER (emergency room) on a stretcher. Resident was acting poorly when he arrived at the hospital. Resident did calm down. Resident out of no where started to act up. Police were called back to the hospital.

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Our staff member who got along with the resident well also went. Once they got there the resident was able to be calmed down. Later about 11 p.m., the resident did get worked up again and the staff member calmed him down". A vulnerable adult report was submitted to the State Agency.

During an interview on 6/3/19, at 5:15 p.m. the director of nursing (DON) stated R1 had been intoxicated and activated the alarm on the main entrance when he walked out to smoke. The DON stated R1 might have been confused as to where the smoking area was. The DON stated staff had witnessed, immediately responded, and assisted R1 to the secured designated smoking area.

During an interview on 6/3/19, at 7:55 p.m. the administrator stated the facility had received a phone call from the police department informing them R1 had eloped from the facility, was found stumbling on the street, and had been taken to the hospital. The administrator stated when the Wanderguard alarm sounded, all staff were responsible to respond and look outside. The administrator stated if a resident was not seen, staff were to alert the charge nurse so a head count could be completed. In addition, the administrator stated if a resident was not found, staff were expected to immediately notify the police.

During an interview on 6/3/19, at 8:32 p.m. a police Sargent from the police department arrived at the facility to discuss R1's event. The sargent stated R1 had been wandering in the middle of the street downtown on Main Street (highway 61), and stated R1 had become disorderly, was placed in handcuffs, then transported to the

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hospital by ambulance.

During an interview on 6/3/19, at 8:38 p.m. police officer (PO)-A arrived at the facility. PO-A stated R1 "was staggering in the middle of Main Street, first spotted on the intersection of Plumb and Main, walked down to the intersection of Main and Bush, a group of citizens successfully got him to the sidewalk." PO-A stated the location was close to a mile from the facility. PO-A stated the call to dispatch came in at 7:34 p.m. PO-A stated when he arrived on the scene, R1 was only identified by the name on his socks, had a Wanderguard bracelet on, was mumbling, and had a strong smell of alcohol. PO-A stated he administered the alcohol breathalyzer test, however R1 instead of blowing, spit into the machine. The results were .032. The PO-A stated from his experience that reading would result in a high blood alcohol level. PO-A stated R1 reported to the officers he had been drinking all day. PO-A verified during the call, R1 had become disorderly and was placed in handcuffs, an ambulance was called, and R1 was transferred to the hospital. PO-A stated R1 remained in cuffs during the transfer, and remained in handcuffs after arrival to the hospital for a short time. PO-A stated the duration R1 was in handcuffs was approximately 30 minutes.

During an interview on 6/4/19, at 7:45 a.m. nursing assistant (NA)-C stated R1 was allowed to freely move about the building without escort, and staff were not instructed to watch R1 when he would leave his unit.NA-C stated residents who have Wanderguards or Accutechs were identified on "Care Cards". NA-C stated there was an alarm system on both the exits to the building however, the door alarms all sounded the

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same with no unique sound dependent on the type of system. NA-C indicated there was a panel at the nurse's station that would display a red light in addition to the audible alarm. NA-C stated staff were to check the doors, enter the code to silence the alarm, look outside, and if a resident was not visible, the charge nurse was to be notified, and a head count performed.

During an interview on 6/4/19, at 8:00 a.m. licensed practical nurse (LPN)-A stated R1 had a Wanderguard on. LPN-A stated R1 had recently started drinking alcohol and stated she was aware of two episodes when R1 had become intoxicated. LPN-A verified R1's care plan lacked a plan for alcohol use. LPN-A stated on 6/3/19, she had last seen R1 at approximately 1:30 p.m. when he left the unit, and did not note his intoxication. LPN-A stated R1 had a Wanderguard on, was free to move around the facility independently, and stated R1 was off the unit more than he was on the unit. LPN-A stated R1 would tell staff he was leaving the unit however, this was not communicated to the other nursing stations for supervision purposes. LPN-A stated once R1 was off the unit, it was the responsibility of the other staff on the different units to supervise him. LPN-A stated it was all staff's responsibility to respond to the Wanderguard alarms, check outside, and if the resident was not found, to ensure a head count was performed.

Also during the interview on 6/4/19 at 8:00 a.m., LPN-A provided history about R1 wanting to leave the building. LPN-A stated prior to R1 leaving the facility on 4/10/19, he had informed several staff of his intentions; staff tried to convince him otherwise. LPN-A stated she had been working

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that morning and the social worker had provided the form to her, and further stated she went over the form with R1. LPN-A stated R1 then left the facility on foot. LPN-A stated at the time the facility was not aware of the guardianship order, and thought R1 was his own person who could make decisions. LPN-A stated she was unsure at that time whether the physician had been made aware R1 had left the facility AMA. LPN- A stated she was unaware of the neuropsych examination dated 12/12/18, that indicated R1 had severe cognitive impairment. LPN-A stated had she been aware of the guardianship order, R1 would have not been allowed to leave AMA, he would have been followed, and the police would have been contacted.

During an interview on 6/4/19, at 8:20 a.m. nursing assistant (NA)-A also provided historical perspective. NA-A stated prior to R1 leaving the facility on 4/10/19, he had told staff for several days he was going to leave the facility. NA-A stated during that time staff would redirect R1, and would tell him it was not a good idea. NA-A stated R1 left the facility AMA on the morning of 4/10/19, wearing several layers of clothes. NA-A was not aware of the level of R1's cognitive impairment, per the neuropsych exam. NA-A indicated R1 had called the facility several times that day reporting his locations to staff and was later returned to the facility by the police department. NA-A further stated R1 had a Wanderguard on, was able to walk around the building independently without escort, and spent a lot of time off the unit downstairs. NA-A stated R1 talked about leaving the facility and going home frequently. NA-A then stated, R1 would alert staff when he was leaving the unit however, unit staff do not communicate to other nursing

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stations when R1 leaves the unit. NA-A stated the Wanderguards were checked for placement every shift, and checked for function every night shift. NA-A verified facility protocol indicated if a door alarm were to go off, staff were to look outside, if resident was not seen, the charge nurse was notified, and a head count done.

During an interview on 6/4/19, at 8:34 a.m. restorative nursing assistant (RNA)-A stated R1 had been drinking a lot during the last couple of weeks. RNA-A indicated an unawareness of whether R1 had anything to drink on 6/3/19, but stated he had spent a lot of time in R2's room and R2 had been drinking. RNA-A stated R1 stated almost daily he wanted to go home. RNA-A further stated an unawareness of whose responsibility it was to supervise R1 once he was off the unit; stated "we all kind of do" and thought the receptionist "kind of knew what is going on".

During an interview on 6/4/19, at 8:42 a.m. NA-B stated R1 frequently stated he wanted to go home more on the evening shift than during the day shift. NA-B stated R1 had a Wanderguard on and was able to move about the facility independently. NA-B stated R1 told staff when he was going downstairs (off the unit) however, stated it was not communicated to other nursing stations when R1 would leave the unit. NA-B also verified it was facility protocol if the Wanderguard went off, all staff were responsible to immediately respond and check outside. NA-B said if a resident was not found, a head count needed to be done.

During an interview on 6/4/19, at 8:58 a.m. LPN-B stated R1 had a Wanderguard on but was able to move around the facility independently. LPN-B

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stated she had worked on 6/3/19 and stated R1 had been good in the morning, had some alcohol in the afternoon, and had been stating he missed home. LPN-B stated around 3:30 p.m., she had notified the administration R1 had been drinking and was not sure how he obtained the alcohol. LPN-B indicated around 4:00 p.m. she had responded to a Wanderguard alarm and had found R1 outside the main entrance smoking a cigarette. LPN-B stated she thought R1 had gone out the wrong door to smoke because he was under the influence. LPN-B indicated on that day, R1 was more difficult to redirect than usual, but she'd assisted R1 to the enclosed smoking area, and notified the administrator. LPN-B stated she worked until 6:00 p.m. and after the incident was not given any other direction pertaining to R1. LPN-B stated when she left the building that evening, R1 was not intoxicated.

During an interview on 6/4/19, at 10:36 a.m. licensed social workers (LSW)-A and LSW-B stated an unawareness of how many residents in the facility were drinking alcohol. LSW-A stated the facility had just implemented a policy for alcohol consumption "today" (6/4/19). LSW-A stated there had not really been a good policy in place from the last owners and the facility had been working on designing and implementing a more comprehensive plan. LSW-A further stated the use of alcohol should be a resident's care plan.

During an interview on 6/4/19, at 11:51 a.m. LPN-C also stated the facility had just implemented a new alcohol policy "today" 6/4/19, and there had been some confusion about ensuring resident rights to drink alcohol that needed to be clarified. LPN-C stated an

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| F 689 | Continued From page 16<br>awareness of R1 drinking alcohol however, was not sure how R1 obtained it.<br><br>The facility was notified of the Immediate Jeopardy for R1 on 6/4/19, at 5:15 p.m. The IJ was removed on 6/5/19, at 4:33 p.m. when the facility had provided an acceptable removal plan, and the plan could be verified as implemented including: All residents with security devices were checked and accounted for; A comprehensive policy and procedure for elopement was developed and implemented; Guidelines for alcohol use were developed; All staff were informed of the revised facility policies and were educated as to how to implement, including procedures for elopement and alcohol use guidelines; and a method of auditing to ensure ongoing compliance was developed and initiated. | F 689 | | |
| F 740 SS=D | Behavioral Health Services<br>CFR(s): 483.40<br><br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to provide necessary behavioral health services related to alcohol use for 3 of 3 residents (R1, R2, R6) reviewed for substance use within | F 740 | R1 IS SAFE BACK AT FACILITY AND IS NO LONGER DRINKING ALCOHOL PER PHYSICIAN ORDER, GUARDIAN'S CONSENT, AND ALCOHOL | 7/3/19 |

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| F 740 | Continued From page 17<br>the facility.<br><br>The findings include:<br><br>R1's quarterly Minimum Data Set (MDS) assessment dated 3/29/19 indicated R1 was independent with transfers, was independent with ambulation on and off the units, and required supervision with hygiene. The MDS also indicated R1 had exhibited rejection of care behaviors 1-3 days during the assessment period.<br><br>R1's admission record, included diagnoses of diffuse traumatic brain injury (TBI), alcohol abuse, and anxiety disorder.<br><br>R1's care plan did not include information related to alcohol use.<br><br>R1's progress notes reviewed included:<br>On 6/3/19, a note documented at 11:39 p.m. indicated earlier in the shift, R1 had been under the influence of alcohol and had eloped from the facility.The note indicated R1 ended up downtown in the middle of a traffic intersection and police were called to contain him due to erratic behaviors. R1 had to be restrained and taken to the emergency room (ER) due to escalating aggressive behaviors.<br>On 6/1/19, at 10:22 p.m. a progress note included: "Writer was called down to 2W [a facility unit] as [R1] was drunk laying on the floor in room [number]. He got up after I told him I was going to call the police. He refused to come upstairs and pulled away from staff. He went outside on smoking patio. Police were called to see if they could get him to comply with going to his room. He walked upstairs with officer. He at some point became aggressive toward the police | F 740 | GUIDELINES. R1'S CAREPLAN REVIEWED AND REVISED.<br><br>R2 IS TRIALING AN ALCOHOL CONSUMPTION PROGRAM BASED ON PHYSICIAN ORDERS AND ALCOHOL GUIDELINES. R2'S CARE PLAN REVIEWED AND REVISED.<br><br>R6 IS NO LONGER DRINKING ALCOHOL PER PHYSICIANS ORDER AND ALCOHOL GUIDELINES. R6'S CARE PLAN REVIEWED AND REVISED.<br><br>ALL OTHER RESIDENTS WITH HISTORY OF ALCOHOLISM HAVE A FOCUSED CARE PLAN.<br><br>ALL RESIDENTS WANTING TO CONSUME ALCOHOL HAVE A CAREPLAN AND/OR AN ORDER FOR USAGE.<br><br>IMPLEMENTATION OF THE RESIDENT ALCOHOL / SUBSTANCE GUIDELINES ON 6/4/2019 AND DISPERSED TO ALL RESIDENTS. POLICY UPDATED 6/20/2019 AND DISPERSED TO ALL RESIDENTS AND STAFF AREAS FOR REVIEW ON 6/21/2019.<br><br>EDUCATION PROVIDED TO ALL STAFF PERTAINING TO THE RESIDENT ALCOHOL/SUBSTANCE GUIDELINES STARTING 6/4/2019. REVIEW EDUCATION WILL BE COMPLETED AT JULY MONTHLY MEETINGS.<br><br>ALCOHOL ASSESSMENT CREATED | |

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| F 740 | Continued From page 18<br>and they took him in police car."<br>R1 incident note dated on 6/3/19, at 9:23 p.m. "was reported to be under the influence of alcohol this shift, [R1] spoken to by staff and supervisor, [a staff name]. [R1] continued to drink then left facility and was picked up by the police and taken to the ER no injuries reported to staff. Msg (message) left for family about incident police report done with Adm (administrator) [name]."<br><br>According to R2's face sheet, R2 was admitted to the facility on 7/23/18, with an admitting diagnosis of abnormality of gait, history of seizures, adjustment disorder and alcohol dependence.<br><br>R2's care plan included the following focus area: "Alteration in behavior AEB (as evidenced by): impulsivity and impaired judgment and persuasive [sic] disregard for the rights of others AEB risk-taking behaviors, irritability, anger and aggressiveness, conflict with authority, history of previous alcohol use, and impulsive, explosive behavior current alcohol use within the facility. Date Initiated 4/21/19" Interventions included: monitor for signs of intoxication, be alert for mood and behavior changes, use a kind and firm approach with calm voice, therapeutic touch, use of eye contact, make 30 minute checks, and one to two sets of vital signs if R2 appears intoxicated. R2's care plan did not include information about R2 drinking with other residents and failed to include directions related to safe storage of alcohol. R2's care plan did not include information about services to provide related to alcohol abuse or behavioral health or social service involvement.<br><br>R2's progress note dated on 6/2/19, at 12:43 p.m., indicated R2 had become intoxicated and | F 740 | AND WILL BE COMPLETED ON EVERY RESIDENT BY JULY 5, 2019 AND THEN QUARTERLY.<br><br>AUDIT 24-72 HOUR REPORT FOR ALCOHOL USE-INTOXICATED BEHAVIORS ONCE A WEEK FOR FOUR WEEKS AND ONCE A MONTH FOR 4 MONTHS.<br><br>OUTCOME WILL BE OBSERVED AT QAPI. DIRECTOR OF NURSING OR DESIGNEE WILL BE RESPONIBLE FOR COMPLIANCE BY 7/5/2019. | |

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| F 740 | Continued From page 19 | F 740 | | |

staff had difficulty rousing the resident. The note indicated staff had taken vitals and later notified the physician of his condition. Staff also found and disposed of open, partially consumed bottles of vodka from R2's room.

According to R6's face sheet, R6 was originally admitted to facility 9/26/18, with a primary diagnosis of repeated falls and adult failure to thrive, and with a documented history of alcohol abuse.

R6's care plan included the following focus area: "I am adjusting ok to my new environment. I have a history of alcoholism and visitors have been trying to bring me alcohol. I have been told that I cannot have alcohol in the facility. Date Initiated: 09/28/2018." Interventions included: observe for changes in acceptance and intervene as needed. R6's care plan failed to include any information on how to care for R6 should he become intoxicated, how to deal with issues of alcohol use within the facility, or how to protect him or others in the case of alcohol misuse. Further, the care plan did not indicate any referral services in the case of abuse of alcohol.

According to R6's progress notes, R6 was found on his floor 5/23/19, with a smell of alcohol. He had an abrasion on his head above his left eyebrow. A prior progress note dated 4/26/19, also indicated R6 had been found on the floor, smelling of alcohol and acting inebriated.

During an interview on 6/4/19, at 8:34 a.m. restorative nursing assistant (RNA)-A stated R1 had been drinking a lot during the last couple of weeks. RNA-A said R1's was in R2 room and R1 had been drinking. RNA-A said R1 stated almost

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| F 740 | Continued From page 20 | F 740 | | |

daily he wanted to go home. RNA-A stated an unawareness of whose responsibility it was to supervise R1 once he was off the unit by saying, "we all kind of do."

During an interview on 6/4/19, at 8:58 a.m. licensed practical nurse (LPN)-B stated she had been working on 6/3/19 when R1 eloped. LPN-B stated R1 had consumed some alcohol in the afternoon, and she had notified the administration around 3:30 p.m. about R1's drinking but was not sure how he had obtained the alcohol. LPN-B said she'd found R1 outside the main entrance smoking a cigarette around 4:00 p.m., and thought he had gone out the wrong door to smoke because he was under the influence of alcohol. LPN-B stated R1 had been more difficult to redirect than usual, but she had assisted R1 to the enclosed smoking area and had notified the administrator.

During an interview on 6/4/19, at 10:15 a.m. R2 stated he kept alcohol in his room but did not supply it to R1. R2 stated R1 obtained alcohol on his own through local friends and that R1 liked to drink whiskey. R2 stated R1 would disguise the alcohol in Gatorade bottles. R2 further stated R1 had been drinking a lot the last few weeks and would come to his room and drink socially. R2 stated over the weekend, R1 was really drunk, and ended up hitting a police officer over the top of the head after which R1 was put in handcuffs and removed from the facility.

According to an interview on 6/4/19 at 8:23 a.m., LPN-D said the facility did not have a resident assessment to be used related to substance abuse upon admission to the facility. LPN-D stated, "This is how it was explained to me,

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previous administration allowed drinking and stuff. Prior to that they didn't. Now it's like we pick up the pieces and try to put them back together. Just putting things together...This past weekend we had someone in the entryway with a whole bottle of booze. It's my understanding [Administrator] wrote a new policy but has to run it past the ombudsman. We do an assessment if we believe they are under the influence, but we call the doctor first." LPN-D continued, "I think the last administrator just wanted to make everyone feel good. He pretty much let everyone do what they wanted. It was not like that before, but all of a sudden it seemed like there was a lot of alcohol." LPN-D further stated residents would state to one another, "I got it last weekend; you get it this weekend." LPN-D stated the facility had been aware of a problem with alcohol and substance use in the building for at least six weeks and had been working on a policy from that time, but it had not yet been instituted.

During interview on 6/4/19, at 8:47 a.m. the facility administrator stated the facility had recently developed a policy regarding resident alcohol use. The administrator stated, "We just put a new policy in place. There are resident rights because this is their home, but we have to consider the problem with disruption in a public space. I wish I'd had this in place before yesterday. We have been working on this since last month. I got the peer review done last week and I had it done around 3 p.m. or so yesterday and sent it to the ombudsman last night... We can't just pull the alcohol from their (resident) rooms. This is their home and we want it to feel like that. Some of these people have been drinking at home and then they come here and because they are "home" all the time, they think

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| F 740 | Continued From page 22 | F 740 | | |

they can just be drinking here. We don't want to say they can't drink, but we need to assure that it is safe." The administrator also addressed the issue of safe storage of alcohol within the facility stating, "It's been a problem in the past. They wanted to store it in the med cart but we didn't think we could just take people's alcohol like that, we have to have a plan. Our policy is going to be that we will store it. Then we can make sure it is safe for the other residents and we can assess if drinking becomes an issue. The policy will go out to everyone at the same time. All staff will know and all residents will know that it [any alcohol discovered] will be brought to nurse's station for the safety of residents-others and themselves." The administrator also stated she thought there was a standard assessment completed if a resident was suspected to have been using alcohol which involved notification of the physician and assessment of vital signs.

During an interview on 6/4/19, at 10:36 a.m. licensed social workers (LSW)-A and LSW-B stated they were unaware of how many residents in the facility were drinking alcohol. LSW-A stated the facility had just implemented a policy for alcohol consumption that day (6/4/19). LSW-A stated there had not been a good policy in place from the previous facility owners and the facility had been working on designing and implementing a more comprehensive plan. LSW-A also stated a resident's use of alcohol should be identified in the resident's care plan.

During interview on 6/4/19, at 11:51 a.m. registered nurse (RN)-A stated the facility had just implemented a new alcohol policy 6/4/19, but there had been some confusion about ensuring resident rights to drink alcohol which needed to

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| F 740 | Continued From page 23<br>be clarified. RN-A stated an awareness of R1 drinking alcohol however, was not sure, how R1 obtained it. | F 740 | | |

Electronically Delivered

June 26, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Numbers H5223152C, H5223155C, H5223151C, H5223149C, H5223148C, H5223150C, H5223153C, H5223154C

Dear Administrator:

A complaint investigation was completed on June 7, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the

Time Period For Correction.

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

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

When all licensing orders are corrected, the form should be signed and returned electronically to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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

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

Sincerely,

Kamala Fiske-Downing

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

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>On 6/3/19 through 6/7/19, surveyors of this Department's staff conducted an investigation of complaint H5223155C. As a result, correction orders were issued at 0830 (4658.0520 Subp. 1) and 1475 (4658.1005 Subp.1)<br><br>The following complaint H5223152C was found to be substantiated with no deficiency cited.<br><br>The following complaints H5223151C, H5223149C, H5223148C, H5223150C, H5223153C, H5223154C were unsubstantiated.<br><br>Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.<br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as | 2 000 | | |

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| 2 000 | Continued From page 2<br>evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to identify, complete assessment, implement interventions and provide supervision for 1 of 1 resident (R1) who consumed alcohol and eloped from the facility. | 2 830 | R1 WAS FOUND AND BROUGHT TO THE HOSPITAL FOR ASSESSMENT. NO INTERNAL OR EXTERNAL INJURIES FROM EVENT. R1'S CAREPLAN REVIEWED AND REVISED. ACCUTEK | 7/7/19 |

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| 2 830 | Continued From page 3<br><br>Findings include:<br><br>R1's neuropsychiatry visit note dated 12/12/18, identified R1's medical history included a traumatic brain injury (TBI) as a result of R1 having been hit by a car when walking along a highway intoxicated. The neuropsychiatry exam indicated R1's IQ score was between 75 and 87, and indicated R1 had reduced safety awareness. In addition, the note included, "He requires a court-ordered guardian to assist him in making healthcare and financial decisions due to severe cognitive impairment." The note also indicated R1 would likely require 24 hour supervision once he returned to the community.<br><br>R1's Admission Record included diagnoses of diffuse traumatic brain injury, alcohol abuse, and anxiety disorder.<br><br>R1's quarterly Minimum Data Set (MDS) assessment dated 3/29/19, indicated R1 was independent with transfers, was independent with ambulation on and off the units, and required supervision with hygiene. The MDS also indicated R1 exhibited rejection of care behaviors 1-3 days during the assessment period.<br><br>R1's Care Area Assessment (CAA) for Behavioral symptoms and Cognitive Loss/Dementia dated 10/18/18, were triggered to be completed by the admission MDS. The Behavioral assessment was not completed, however identified R1 to have a head injury, pain, and verbal behaviors directed at others. The Cognitive Loss CAA was also not completed, however indicated this CAA was triggered because of diagnosis of TBI, assessed mood state, behavioral symptoms, and presence of pain coded on the MDS during the assessment | 2 830 | APPLIED UPON RETURN. ACCUTEK SYSTEM SECURES THE ELEVATORS AND 3 EAST ENTRANCE.<br><br>ALL RESIDENTS HAD THE NEW ELOPEMENT ASSESSMENT COMPLETED ON 6/5/2019.<br><br>IMPLEMENTATION OF THE ELOPEMENT BINDER INCLUDING: POLICY ON ELOPEMENT RISK, POLICY ON MISSING RESIDENT, CHECKLIST, ELOPEMENT ASSESSMENT, SEARCH LOG, LIST OF CODES, AND SKIN ASSESSMENT ON 6/4/2019.<br><br>PICTURE OF EACH RESIDENT WITH ELOPEMENT RISK IN eLOPEMENT BINDERS AT EACH UNIT AND AT RECEPTION DESK.<br><br>EDUCATION WAS PROVIDED TO ALL STAFF PERTAINING TO EXPECTATION FOR ELOPEMENT/ELOPEMENT BINDER STARTING 6/4/2019. REVIEW EDUCATION WILL BE COMPLETED AT JULY MONTHLY MEETINGS.<br><br>ELOPEMENT DRILL COMPLETED ON 6/10/2019 AND WILL BE COMPLETED ONCE A MONTH FOR 4 MONTHS.<br><br>OUTCOME WILL BE OBSERVED AT QAPI. THE DIRECTOR OF NURSING OR DESIGNEE WILL BE RESPONSIBLE FOR COMPLIANCE BY JULY 5, 2019. | |

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| 2 830 | Continued From page 4<br>period.<br><br>R1's current care plan provided on 6/6/19, indicated R1 was independent with ambulation, transfers, and toileting. The care plan also indicated R1 had cognitive impairment related to TBI. The goals directed staff to anticipate his needs, and staff along with guardian to assist in decision-making. The care plan for elopement risk initiated 10/18/18, indicated R1 was at risk for elopement related to "making statements as wanting to leave, sufficient mobility to exit unescorted loitering near exits; unawareness of need for care/supervision due to cognitive and emotional symptoms". The associated interventions directed staff to apply Wanderguard and Accutech on left wrist. The care plan also indicated a trial removal of the devices was conducted however, R1 eloped from the facility on 12/17/18, with the intention of walking to Bemidji, Minnesota.<br><br>During the facility tour, the facility was observed to have 3 floors with resident elevators that were not secured. In addition, the facility was also observed to be divided into separate nursing units. The facility exits were observed to have a Wanderguard System. The system was identified to use battery operated bracelets applied to residents who were determined to be at risk for elopement. The bracelets omit radio waves, which sounds an audible alarm if the bracelet is in near proximity to an exit. The system did not prevent residents from exiting the building. The third floor had a semi-secured unit which utilized an Accutech system. Upon review, the Accutech system was similar to the Wanderguard system however, the Accutech system automatically locked the unit doors from both sides when a resident was near the unit exit doors. The | 2 830 | | |

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| 2 830 | Continued From page 5<br><br>Accutech system was only utilized on the exit doors to the third floor unit but nowhere else in the facility. R1 resided on the 3rd floor semi-secured unit.<br><br>R1's Elopement Risk Assessment dated 12/10/18, indicated since R1 did not have a history of elopement attempts, and hadn't demonstrated current elopement behaviors, the Wanderguard and Accutech were removed.<br><br>R1's progress note dated 12/17/18, at 8:15 a.m. indicated R1 was spotted walking west on highway 61, the administrator was notified, and 911 was called. That same day at 10:38 a.m., a progress note indicated the police had still not found R1. The note further indicated events prior to R1 being found on the highway included: R1 had told staff he was going to go smoke outside and when nurse went to give R1 medications, R1 was not found and a facility wide search was initiated. At 12:24 p.m. on 12/17/18, the progress note indicated the police had returned R1 to the facility at 11:45 a.m. A subsequent progress note documented 12/17/18 at 1:36 p.m., indicated R1 had again left the facility however, a staff member was following him, and R1 was returned to the facility with the help of the police. The progress note dated 12/17/18 at 3:34 p.m., indicated staff had placed a Wanderguard on R1's left wrist. However, the Accutech system was not put in place.<br><br>R1's physician progress note dated 2/12/19, included: "He [R1] continues to have severe cognitive deficits and physical limitations, has reduced safety awareness and will likely require 24 hour supervision when he is ready to discharge from the facility. Neuro-psych testing confirmed this, and advised for a guardian." The | 2 830 | | |

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note also indicated R1 was unaware of deficits, had poor judgment, and requested to go home.

R1's physician progress note dated 3/22/19, indicated the evaluations from the physician visit 2/12/19, and now included, "Patient has used alcohol regularly," and was insistent he needed to go home.

R1's progress note dated 3/22/19, indicated R1 did not need to be escorted off the semi-secured unit and was allowed to go out to the secured courtyard to smoke on his own.

R1's Elopement Risk Assessment dated 3/29/19, included R1 was at risk for elopement. The assessment indicated after the Accutech and Wanderguard had been removed, R1 had walked out/eloped from the facility on 12/17/18, in an effort to return home, which placed R1 in harm's way because he walked on a highway, and attempted to hitchhike. The assessment indicated R1 had talked about leaving the facility to go home. The environmental risk section indicated the facility was near a busy street near woods and hills, and indicated water was on the grounds.

R1's social services progress note dated 4/9/19 at 12:18 p.m. included, "Resident let writer know he plans on leaving AMA tomorrow (4/10/19) at 0500 [5:00 a.m.]. His plans are to get to the bus station "in the cities" and take that to Bemidji. It was explained to him that this facility is not able to send meds or prescriptions with him."

R1's record lacked evidence R1's family members and the physician were notified of R1's plan to leave the facility.

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| 2 830 | Continued From page 7<br><br>R1's progress note dated 4/10/19, at 10:38 a.m. included, "Resident left facility on AMA at 0950 (9:50 a.m.)." The record indicated even though R1 had significant cognitive impairment and required 24-hour supervision, the facility provided R1 a form to make the medical decision to leave the facility AMA to which R1 signed the form and left the facility. (According to the National Weather Service records, on 4/10/19, the high temperature was 36 degrees with a low of 34 degrees).<br><br>The Facility Release for Responsibility For Discharge form dated 4/10/19, at 9:40 a.m. included, "This is to certify that I, [resident name], a resident at Bayview Nursing and Rehab, am leaving against the advice of the attending physician [physician name], and of the nursing home administration, and absolve the management of the said care facility, it's personnel and the attending physician of responsibility for any ill effects or any deterioration in condition, or accident which may result from such." The form was signed by R1 and licensed practical nurse (LPN)-A.<br><br>R1's progress notes indicated on 4/10/19 at 1:23 p.m., a family member was notified (nearly 3.5 hours after R1 had left the facility AMA), R1 had left AMA. The notes indicated R1 had subsequently called the facility, time of call was not documented, informing staff he was at the hospital drinking coffee. A note at 2:35 p.m., indicated a different family member had called inquiring why the facility had allowed R1 to leave the facility. The progress note indicated it was explained to the family member the facility had explained the risks and benefits to R1 about leaving, and R1 had still made the decision to leave. The note then indicated the facility had | 2 830 | | |

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previously been unaware a court had awarded emergency guardianship to the family, and did not have record of the court ordered judgment, which was then provided to the facility. The court guardianship document dated 1/31/19, indicated emergency guardianship was granted to family members as of that date because R1 could not manage his own care and could not make his own decisions.

A progress note dated 4/10/19 at 5:49 p.m., indicated the resident was returned to the facility by the police 8 hours after he'd left the facility. The note also indicated upon R1's return, a Wanderguard device was applied to his left wrist.

R1's elopement care plan had an intervention added 4/16/19, that directed staff to immediately call the police department if R1 left the facility.

R1's physician visit notes from a 4/22/19 visit, included the aforementioned evaluations from the physician's visit 3/22/19, and indicated R1 continued to utilize alcohol and insist on returning home.

R1's progress note dated 5/5/19, at 1:27 a.m. indicated R1 had been observed on the 1st floor nursing unit at 10:15 p.m. with an unsteady gait, slurred speech, and a cup of juice that smelled like Vodka. The note indicated R1 was assisted to bed. A progress note dated 5/23/19, indicated R1 had been drinking alcohol several times over the weekend.

R1's physician visit note dated 5/14/19, continued to reflect R1's persistent alcohol use and insistence to return home.

R1's progress notes from 5/23/19, at 6:11 p.m.

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indicated R1 had pain in his right shoulder and was sent to the emergency room for further evaluation.. The note indicated R1 had returned at 2:27 a.m. on 5/24/19.

A progress note dated 5/30/19, at 4:01 p.m. included "Resident stated the ER cut off his Wanderguard. New Wanderguard placed."

R1's treatment administration record (TAR) directed staff to check Wanderguard placement every shift and directed the night shift staff to check placement and function. The TAR had checked marked boxes with initials that indicated the Wanderguard was checked for placement and function as directed on all days and shifts between 5/24/19, and 5/30/19, even though the Wanderguard had been removed in the emergency room 5/23/19.

A progress note dated 6/1/19, at 10:22 p.m. indicated R1 was on the 2nd floor of facility, drunk, laying on the floor of another resident's room. The note indicated R1 had refused to go upstairs to his unit so the police were called. Further, the note indicated R1 became physically aggressive with the officer, and was escorted out of the facility by the officer. R1 returned to the facility on 6/2/19, at 7:30 a.m.

An emergency room visit note dated 6/1/19, indicated R1 had a history of cognitive disorder related to TBI and had presented to the emergency room via police for evaluation of alcohol intoxication. The note included: "The patient states he has consumed a gallon of vodka tonight and was a common occurrence for him". The note also indicated the police department reported that the patient (R1) had been consistently consuming alcohol for the past six

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weeks but they were unsure how he was obtaining it. The visit note also included R1's blood alcohol level was high. The note indicated R1 was discharged back to the facility for monitoring with no new orders.

R1's Incident Report note dated 6/3/19, at 9:23 p.m. indicated R1 was reported to be under the influence of alcohol, continued to drink, left the facility and was picked up by the police, and was taken to the emergency room with no injuries. The report indicated at 9:50 p.m., the physician was contacted in regards to R1 leaving the facility, and the interdisciplinary team had made the decision to re-implement the Accutech system until the family responded to phone calls.

R1's progress note dated 6/3/19, at 11:39 p.m. indicated R1 had accidentally gone out the wrong door to smoke, staff had seen this happen and brought R1 to the right area. The note indicated the family was contacted with a request to activate the Accutech system, and the MD had given orders to hold risk medications. The note furhter included, "Police officer called the facility stating that our resident was found downtown and they were bringing him to the hospital. Officer stated that the resident was found down by main street acting disorderly. The police officer went to approach the resident but resident acted like he might get aggressive. The resident was handcuffed and driven to the ER (emergency room) on a stretcher. Resident was acting poorly when he arrived at the hospital. Resident did calm down. Resident out of no where started to act up. Police were called back to the hospital. Our staff member who got along with the resident well also went. Once they got there the resident was able to be calmed down. Later about 11 p.m., the resident did get worked up again and

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| 2 830 | Continued From page 11<br>the staff member calmed him down". A vulnerable adult report was submitted to the State Agency.<br><br>During an interview on 6/3/19, at 5:15 p.m. the director of nursing (DON) stated R1 had been intoxicated and activated the alarm on the main entrance when he walked out to smoke. The DON stated R1 might have been confused as to where the smoking area was. The DON stated staff had witnessed, immediately responded, and assisted R1 to the secured designated smoking area.<br><br>During an interview on 6/3/19, at 7:55 p.m. the administrator stated the facility had received a phone call from the police department informing them R1 had eloped from the facility, was found stumbling on the street, and had been taken to the hospital. The administrator stated when the Wanderguard alarm sounded, all staff were responsible to respond and look outside. The administrator stated if a resident was not seen, staff were to alert the charge nurse so a head count could be completed. In addition, the administrator stated if a resident was not found, staff were expected to immediately notify the police.<br><br>During an interview on 6/3/19, at 8:32 p.m. a police sergeant from the police department arrived at the facility to discuss R1's event. The sergeant stated R1 had been wandering in the middle of the street downtown on Main Street (highway 61), and stated R1 had become disorderly, was placed in handcuffs, then transported to the hospital by ambulance.<br><br>During an interview on 6/3/19, at 8:38 p.m. police officer (PO)-A arrived at the facility. PO-A stated | 2 830 | | |

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| 2 830 | Continued From page 12<br><br>R1 "was staggering in the middle of Main Street, first spotted on the intersection of Plumb and Main, walked down to the intersection of Main and Bush, a group of citizens successfully got him to the sidewalk." PO-A stated the location was close to a mile from the facility. PO-A stated the call to dispatch came in at 7:34 p.m. PO-A stated when he arrived on the scene, R1 was only identified by the name on his socks, had a Wanderguard bracelet on, was mumbling, and had a strong smell of alcohol. PO-A stated he administered the alcohol breathalyzer test, however R1 instead of blowing, spit into the machine. The results were .032. The PO-A stated from his experience that reading would result in a high blood alcohol level. PO-A stated R1 reported to the officers he had been drinking all day. PO-A verified during the call, R1 had become disorderly and was placed in handcuffs, an ambulance was called, and R1 was transferred to the hospital. PO-A stated R1 remained in cuffs during the transfer, and remained in handcuffs after arrival to the hospital for a short time. PO-A stated the duration R1 was in handcuffs was approximately 30 minutes.<br><br>During an interview on 6/4/19, at 7:45 a.m. nursing assistant (NA)-C stated R1 was allowed to freely move about the building without escort, and staff were not instructed to watch R1 when he would leave his unit. NA-C stated residents who have Wanderguard's or Accutechs were identified on "Care Cards". NA-C stated there was an alarm system on both the exits to the building however, the door alarms all sounded the same with no unique sound dependent on the type of system. NA-C indicated there was a panel at the nurse's station that would display a red light in addition to the audible alarm. NA-C stated staff were to check the doors, enter the code to silence | 2 830 | | |

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the alarm, look outside, and if a resident was not visible, the charge nurse was to be notified, and a head count performed.

During an interview on 6/4/19, at 8:00 a.m. licensed practical nurse (LPN)-A stated R1 had a Wanderguard on. LPN-A stated R1 had recently started drinking alcohol and stated she was aware of two episodes when R1 had become intoxicated. LPN-A verified R1's care plan lacked a plan for alcohol use. LPN-A stated on 6/3/19, she had last seen R1 at approximately 1:30 p.m. when he left the unit, and did not note his intoxication. LPN-A stated R1 had a Wanderguard on, was free to move around the facility independently, and stated R1 was off the unit more than he was on the unit. LPN-A stated R1 would tell staff he was leaving the unit however, this was not communicated to the other nursing stations for supervision purposes. LPN-A stated once R1 was off the unit, it was the responsibility of the other staff on the different units to supervise him. LPN-A stated it was all staff's responsibility to respond to the Wanderguard alarms, check outside, and if the resident was not found, to ensure a head count was performed.

Also during the interview on 6/4/19 at 8:00 a.m., LPN-A provided history about R1 wanting to leave the building. LPN-A stated prior to R1 leaving the facility on 4/10/19, he had informed several staff of his intentions; staff tried to convince him otherwise. LPN-A stated she had been working that morning and the social worker had provided the form to her, and further stated she went over the form with R1. LPN-A stated R1 then left the facility on foot. LPN-A stated at the time the facility was not aware of the guardianship order, and thought R1 was his own person who could

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make decisions. LPN-A stated she was unsure at that time whether the physician had been made aware R1 had left the facility AMA. LPN- A stated she was unaware of the neuropsych examination dated 12/12/18, that indicated R1 had severe cognitive impairment. LPN-A stated had she been aware of the guardianship order, R1 would have not been allowed to leave AMA, he would have been followed, and the police would have been contacted.

During an interview on 6/4/19, at 8:20 a.m. nursing assistant (NA)-A also provided historical perspective. NA-A stated prior to R1 leaving the facility on 4/10/19, he had told staff for several days he was going to leave the facility. NA-A stated during that time staff would redirect R1, and would tell him it was not a good idea. NA-A stated R1 left the facility AMA on the morning of 4/10/19, wearing several layers of clothes. NA-A was not aware of the level of R1's cognitive impairment, per the neuropsych exam. NA-A indicated R1 had called the facility several times that day reporting his locations to staff and was later returned to the facility by the police department. NA-A further stated R1 had a Wanderguard on, was able to walk around the building independently without escort, and spent a lot of time off the unit downstairs. NA-A stated R1 talked about leaving the facility and going home frequently. NA-A then stated, R1 would alert staff when he was leaving the unit however, unit staff do not communicate to other nursing stations when R1 leaves the unit. NA-A stated the Wanderguards were checked for placement every shift, and checked for function every night shift. NA-A verified facility protocol indicated if a door alarm were to go off, staff were to look outside, if resident was not seen, the charge nurse was notified, and a head count done.

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| 2 830 | Continued From page 15<br><br>During an interview on 6/4/19, at 8:34 a.m. restorative nursing assistant (RNA)-A stated R1 had been drinking a lot during the last couple of weeks. RNA-A indicated an unawareness of whether R1 had anything to drink on 6/3/19, but stated he had spent a lot of time in R2's room and R2 had been drinking. RNA-A stated R1 stated almost daily he wanted to go home. RNA-A further stated an unawareness of whose responsibility it was to supervise R1 once he was off the unit; stated "we all kind of do" and thought the receptionist "kind of knew what is going on".<br><br>During an interview on 6/4/19, at 8:42 a.m. NA-B stated R1 frequently stated he wanted to go home more on the evening shift than during the day shift. NA-B stated R1 had a Wanderguard on and was able to move about the facility independently. NA-B stated R1 told staff when he was going downstairs (off the unit) however, stated it was not communicated to other nursing stations when R1 would leave the unit. NA-B also verified it was facility protocol if the Wanderguard went off, all staff were responsible to immediately respond and check outside. NA-B said if a resident was not found, a head count needed to be done.<br><br>During an interview on 6/4/19, at 8:58 a.m. LPN-B stated R1 had a Wanderguard on but was able to move around the facility independently. LPN-B stated she had worked on 6/3/19 and stated R1 had been good in the morning, had some alcohol in the afternoon, and had been stating he missed home. LPN-B stated around 3:30 p.m., she had notified the administration R1 had been drinking and was not sure how he obtained the alcohol. LPN-B indicated around 4:00 p.m. she had responded to a Wanderguard alarm and had | 2 830 | | |

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found R1 outside the main entrance smoking a cigarette. LPN-B stated she thought R1 had gone out the wrong door to smoke because he was under the influence. LPN-B indicated on that day, R1 was more difficult to redirect than usual, but she'd assisted R1 to the enclosed smoking area, and notified the administrator. LPN-B stated she worked until 6:00 p.m. and after the incident was not given any other direction pertaining to R1. LPN-B stated when she left the building that evening, R1 was not intoxicated.

During an interview on 6/4/19, at 10:36 a.m. licensed social workers (LSW)-A and LSW-B stated an unawareness of how many residents in the facility were drinking alcohol. LSW-A stated the facility had just implemented a policy for alcohol consumption "today" (6/4/19). LSW-A stated there had not really been a good policy in place from the last owners and the facility had been working on designing and implementing a more comprehensive plan. LSW-A further stated the use of alcohol should be a resident's care plan.

During an interview on 6/4/19, at 11:51 a.m. LPN-C also stated the facility had just implemented a new alcohol policy "today" 6/4/19, and there had been some confusion about ensuring resident rights to drink alcohol that needed to be clarified. LPN-C stated an awareness of R1 drinking alcohol however, was not sure how R1 obtained it.

The facility was notified of the Immediate Jeopardy for R1 on 6/4/19, at 5:15 p.m. The IJ was removed on 6/5/19, at 4:33 p.m. when the facility had provided an acceptable removal plan, and the plan could be verified as implemented including: All residents with security devices were

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| 2 830 | Continued From page 17<br>checked and accounted for; A comprehensive policy and procedure for elopement was developed and implemented; Guidelines for alcohol use were developed; All staff were informed of the revised facility policies and were educated as to how to implement, including procedures for elopement and alcohol use guidelines; and a method of auditing to ensure ongoing compliance was developed and initiated.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review, revise policies and procedures regarding implementation of alcohol consumption, supervision, identification of resident's at risk for elopement, and wander alert system, Facility staff could be educated on these policies and procedures. The administrator, DON or designee could develop a monitoring system to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 2 830 | | |
| 21475 | MN Rule 4658.1005 Subp. 1 Social Services: General Requirements<br><br>Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services.<br><br>This MN Requirement is not met as evidenced by: | 21475 | | 7/7/19 |

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| 21475 | Continued From page 18<br><br>Based on interview and record review, the facility failed to provide necessary behavioral health services related to alcohol use for 3 of 3 residents (R1, R2, R6) reviewed for substance use within the facility.<br><br>The findings include:<br><br>R1's quarterly Minimum Data Set (MDS) assessment dated 3/29/19 indicated R1 was independent with transfers, was independent with ambulation on and off the units, and required supervision with hygiene. The MDS also indicated R1 had exhibited rejection of care behaviors 1-3 days during the assessment period.<br><br>R1's admission record, included diagnoses of diffuse traumatic brain injury (TBI), alcohol abuse, and anxiety disorder.<br><br>R1's care plan did not include information related to alcohol use.<br><br>R1's progress notes reviewed included:<br>On 6/3/19, a note documented at 11:39 p.m. indicated earlier in the shift, R1 had been under the influence of alcohol and had eloped from the facility.The note indicated R1 ended up downtown in the middle of a traffic intersection and police were called to contain him due to erratic behaviors. R1 had to be restrained and taken to the emergency room (ER) due to escalating aggressive behaviors.<br>On 6/1/19, at 10:22 p.m. a progress note included: "Writer was called down to 2W [a facility unit] as [R1] was drunk laying on the floor in room [number]. He got up after I told him I was going to call the police. He refused to come upstairs and pulled away from staff. He went outside on smoking patio. Police were called to | 21475 | R1 IS SAFE BACK AT FACILITY AND IS NO LONGER DRINKING ALCOHOL PER PHYSICIAN ORDER, GUARDIAN'S CONSENT, AND ALCOHOL GUIDELINES. R1'S CAREPLAN REVIEWED AND REVISED.<br><br>R2 IS TRIALING AN ALCOHOL CONSUMPTION PROGRAM BASED ON PHYSICIAN ORDERS AND ALCOHOL GUIDELINES. R2'S CARE PLAN REVIEWED AND REVISED.<br><br>R6 IS NO LONGER DRINKING ALCOHOL PER PHYSICIANS ORDER AND ALCOHOL GUIDELINES. R6'S CARE PLAN REVIEWED AND REVISED.<br><br>ALL OTHER RESIDENTS WITH HISTORY OF ALCOHOLISM HAVE A FOCUSED CARE PLAN.<br><br>ALL RESIDENTS WANTING TO CONSUME ALCOHOL HAVE A CAREPLAN AND/OR AN ORDER FOR USAGE.<br><br>IMPLEMENTATION OF THE RESIDENT ALCOHOL / SUBSTANCE GUIDELINES ON 6/4/2019 AND DISPERSED TO ALL RESIDENTS. POLICY UPDATED 6/20/2019 AND DISPERSED TO ALL RESIDENTS AND STAFF AREAS FOR REVIEW ON 6/21/2019.<br><br>EDUCATION PROVIDED TO ALL STAFF PERTAINING TO THE RESIDENT ALCOHOL/SUBSTANCE GUIDELINES STARTING 6/4/2019. REVIEW EDUCATION WILL BE COMPLETED AT | |

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| 21475 | Continued From page 19<br>see if they could get him to comply with going to his room. He walked upstairs with officer. He at some point became aggressive toward the police and they took him in police car."<br>R1 incident note dated on 6/3/19, at 9:23 p.m. "was reported to be under the influence of alcohol this shift, [R1] spoken to by staff and supervisor, [a staff name]. [R1] continued to drink then left facility and was picked up by the police and taken to the ER no injuries reported to staff. Msg (message) left for family about incident police report done with Adm (administrator) [name]."<br><br>According to R2's face sheet, R2 was admitted to the facility on 7/23/18, with an admitting diagnosis of abnormality of gait, history of seizures, adjustment disorder and alcohol dependence.<br><br>R2's care plan included the following focus area: "Alteration in behavior AEB (as evidenced by): impulsivity and impaired judgment and persuasive [sic] disregard for the rights of others AEB risk-taking behaviors, irritability, anger and aggressiveness, conflict with authority, history of previous alcohol use, and impulsive, explosive behavior current alcohol use within the facility. Date Initiated 4/21/19" Interventions included: monitor for signs of intoxication, be alert for mood and behavior changes, use a kind and firm approach with calm voice, therapeutic touch, use of eye contact, make 30 minute checks, and one to two sets of vital signs if R2 appears intoxicated. R2's care plan did not include information about R2 drinking with other residents and failed to include directions related to safe storage of alcohol. R2's care plan did not include information about services to provide related to alcohol abuse or behavioral health or social service involvement. | 21475 | JULY MONTHLY MEETINGS.<br><br>ALCOHOL ASSESSMENT CREATED AND WILL BE COMPLETED ON EVERY RESIDENT BY JULY 5, 2019 AND THEN QUARTERLY.<br><br>AUDIT 24-72 HOUR REPORT FOR ALCOHOL USE-INTOXICATED BEHAVIORS ONCE A WEEK FOR FOUR WEEKS AND ONCE A MONTH FOR 4 MONTHS.<br><br>OUTCOME WILL BE OBSERVED AT QAPI. DIRECTOR OF NURSING OR DESIGNEE WILL BE RESPONIBLE FOR COMPLIANCE BY 7/5/2019. | |

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R2's progress note dated on 6/2/19, at 12:43 p.m., indicated R2 had become intoxicated and staff had difficulty rousing the resident. The note indicated staff had taken vitals and later notified the physician of his condition. Staff also found and disposed of open, partially consumed bottles of vodka from R2's room.

According to R6's face sheet, R6 was originally admitted to facility 9/26/18, with a primary diagnosis of repeated falls and adult failure to thrive, and with a documented history of alcohol abuse.

R6's care plan included the following focus area: "I am adjusting ok to my new environment. I have a history of alcoholism and visitors have been trying to bring me alcohol. I have been told that I cannot have alcohol in the facility. Date Initiated: 09/28/2018." Interventions included: observe for changes in acceptance and intervene as needed. R6's care plan failed to include any information on how to care for R6 should he become intoxicated, how to deal with issues of alcohol use within the facility, or how to protect him or others in the case of alcohol misuse. Further, the care plan did not indicate any referral services in the case of abuse of alcohol.

According to R6's progress notes, R6 was found on his floor 5/23/19, with a smell of alcohol. He had an abrasion on his head above his left eyebrow. A prior progress note dated 4/26/19, also indicated R6 had been found on the floor, smelling of alcohol and acting inebriated.

During an interview on 6/4/19, at 8:34 a.m. restorative nursing assistant (RNA)-A stated R1 had been drinking a lot during the last couple of weeks. RNA-A said R1's was in R2 room and R1

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had been drinking. RNA-A said R1 stated almost daily he wanted to go home. RNA-A stated an unawareness of whose responsibility it was to supervise R1 once he was off the unit by saying, "we all kind of do."

During an interview on 6/4/19, at 8:58 a.m. licensed practical nurse (LPN)-B stated she had been working on 6/3/19 when R1 eloped. LPN-B stated R1 had consumed some alcohol in the afternoon, and she had notified the administration around 3:30 p.m. about R1's drinking but was not sure how he had obtained the alcohol. LPN-B said she'd found R1 outside the main entrance smoking a cigarette around 4:00 p.m., and thought he had gone out the wrong door to smoke because he was under the influence of alcohol. LPN-B stated R1 had been more difficult to redirect than usual, but she had assisted R1 to the enclosed smoking area and had notified the administrator.

During an interview on 6/4/19, at 10:15 a.m. R2 stated he kept alcohol in his room but did not supply it to R1. R2 stated R1 obtained alcohol on his own through local friends and that R1 liked to drink whiskey. R2 stated R1 would disguise the alcohol in Gatorade bottles. R2 further stated R1 had been drinking a lot the last few weeks and would come to his room and drink socially. R2 stated over the weekend, R1 was really drunk, and ended up hitting a police officer over the top of the head after which R1 was put in handcuffs and removed from the facility.

According to an interview on 6/4/19 at 8:23 a.m., LPN-D said the facility did not have a resident assessment to be used related to substance abuse upon admission to the facility. LPN-D stated, "This is how it was explained to me,

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previous administration allowed drinking and stuff. Prior to that they didn't. Now it's like we pick up the pieces and try to put them back together. Just putting things together...This past weekend we had someone in the entryway with a whole bottle of booze. It's my understanding [Administrator] wrote a new policy but has to run it past the ombudsman. We do an assessment if we believe they are under the influence, but we call the doctor first." LPN-D continued, "I think the last administrator just wanted to make everyone feel good. He pretty much let everyone do what they wanted. It was not like that before, but all of a sudden it seemed like there was a lot of alcohol." LPN-D further stated residents would state to one another, "I got it last weekend; you get it this weekend." LPN-D stated the facility had been aware of a problem with alcohol and substance use in the building for at least six weeks and had been working on a policy from that time, but it had not yet been instituted.

During interview on 6/4/19, at 8:47 a.m. the facility administrator stated the facility had recently developed a policy regarding resident alcohol use. The administrator stated, "We just put a new policy in place. There are resident rights because this is their home, but we have to consider the problem with disruption in a public space. I wish I'd had this in place before yesterday. We have been working on this since last month. I got the peer review done last week and I had it done around 3 p.m. or so yesterday and sent it to the ombudsman last night... We can't just pull the alcohol from their (resident) rooms. This is their home and we want it to feel like that. Some of these people have been drinking at home and then they come here and because they are "home" all the time, they think they can just be drinking here. We don't want to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00149 | A. BUILDING: _____ B. WING _____ | C 06/07/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BAY VIEW NURSING & REHABILITATION CEN | 1412 WEST FOURTH STREET RED WING, MN 55066 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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say they can't drink, but we need to assure that it is safe." The administrator also addressed the issue of safe storage of alcohol within the facility stating, "It's been a problem in the past. They wanted to store it in the med cart but we didn't think we could just take people's alcohol like that, we have to have a plan. Our policy is going to be that we will store it. Then we can make sure it is safe for the other residents and we can assess if drinking becomes an issue. The policy will go out to everyone at the same time. All staff will know and all residents will know that it [any alcohol discovered] will be brought to nurse's station for the safety of residents-others and themselves." The administrator also stated she thought there was a standard assessment completed if a resident was suspected to have been using alcohol which involved notification of the physician and assessment of vital signs.

During an interview on 6/4/19, at 10:36 a.m. licensed social workers (LSW)-A and LSW-B stated they were unaware of how many residents in the facility were drinking alcohol. LSW-A stated the facility had just implemented a policy for alcohol consumption that day (6/4/19). LSW-A stated there had not been a good policy in place from the previous facility owners and the facility had been working on designing and implementing a more comprehensive plan. LSW-A also stated a resident's use of alcohol should be identified in the resident's care plan.

During interview on 6/4/19, at 11:51 a.m. registered nurse (RN)-A stated the facility had just implemented a new alcohol policy 6/4/19, but there had been some confusion about ensuring resident rights to drink alcohol which needed to be clarified. RN-A stated an awareness of R1 drinking alcohol however, was not sure, how R1

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| 21475 | Continued From page 24<br>obtained it.<br><br>SUGGESTED METHOD OF CORRECTION:<br><br>Administrator and social workers or designee could work with the interdisciplinary team to design an assessment for substance use and abuse to be used upon admission to the facility and at least yearly or as needed. The Administrator and social workers or designee could also define a plan for how to provide or refer persons with substance abuse issues to the most appropriate services for their condition. Furthermore, the IDT team could develop a safe storage plan for the safe and appropriate use of alcohol within the facility.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21475 | | |