

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: 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• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 26, 2019 be rescinded as of July 7, 2019.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

Licensing and Certification Program Minnesota Department of Health

Kamala Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

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



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

Licensing and Certification Program Minnesota Department of Health

Kamala Fiske Downing

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

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

PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		245223	B. WING			C <b>06/07/2019</b>	
	PROVIDER OR SUPPLIER  N NURSING & REHAL	BILITATION CENTER		14	REET ADDRESS, CITY, STATE, ZIP CODE  12 WEST FOURTH STREET  ED WING, MN 55066		
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	enrolled in ePOC, y at the bottom of the form. Your electron	our signature is not required first page of the CMS-2567 ic submission of the POC will	JATLIRE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	on-site revisit of you validate that substate regulations has been your verification. Free of Accident HacFR(s): 483.25(d)( §483.25(d) Accident The facility must en §483.25(d)(1) The as free of accident supervision and assaccidents. This REQUIREMED by: Based on interview failed to identify, complement interven for 1 of 1 resident (and eloped from the in an immediate jet of the IJ began on 6/4/19, at 5:15 p.m administrator, and informed of the IJ.	acceptable electronic POC, an ar facility will be conducted to intial compliance with the en attained in accordance with azards/Supervision/Devices 1)(2)  ats. asure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced and record review, the facility implete assessment, tions and provide supervision R1) who consumed alcohole facility. This failure resulted opardy (IJ) for R1.  3/19, following an elopement le R1 was intoxicated. On the facility owner, director of nursing were The IJ was removed on 6/5/19, er, noncompliance remained	F 689	R1 WAS FOUND AND BROUGHT THE HOSPITAL FOR ASSESSMEN INTERNAL OR EXTERNAL INJURI FROM EVENT. R1'S CAREPLAN REVIEWED AND REVISED. ACCU' APPLIED UPON RETURN. ACCUT SYSTEM SECURES THE ELEVATO AND 3 EAST ENTRANCE.  ALL RESIDENTS HAD THE NEW ELOPEMENT ASSESSMENT COMPLETED ON 6/5/2019.  IMPLEMENTATION OF THE	IT. NO ES TEK EK DRS
	Findings include: R1's neuropsychiat	ric visit note dated 12/12/18,		ELOPEMENT BINDER INCLUDING POLICY ON ELOPEMENT RISK, PO ON MISSING RESIDENT, CHECKL ELOPEMENT ASSESSMENT, SEA	OLICY IST,

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
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F 689	identified R1's med traumatic brain injulhaving been hit by highway intoxicated indicated R1's IQ s and indicated R1 h In addition, the not court-ordered guar healthcare and finat cognitive impairmed would likely required returned to the contract of the	lical history included a lary (TBI) as a result of R1 a car when walking along a d. The neuropsychiatric exam core was between 75 and 87, ad reduced safety awareness. It included, "He requires a dian to assist him in making ancial decisions due to severe nt." The note also indicated R1 at 24 hour supervision once he naminity.  Cord included diagnoses of rain injury, alcohol abuse, and mum Data Set (MDS) 3/29/19, indicated R1 was ransfers, was independent with off the units, and required giene. The MDS also indicated ion of care behaviors 1-3 days	F6	689	LOG, LIST OF CODES, AND SKIN ASSESSMENT ON 6/4/2019.  PICTURE OF EACH RESIDENT WELOPEMENT RISK IN eLOPEMENT BINDERS AT EACH UNIT AND AT RECEPTION DESK.  EDUCATION WAS PROVIDED TO STAFF PERTAINING TO EXPECT FOR ELOPEMENT/ELOPEMENT BINDER STARTING 6/4/2019. REVEDUCATION WILL BE COMPLETE JULY MONTHLY MEETINGS.  ELOPEMENT DRILL COMPLETE 6/10/2019 AND WILL BE COMPLETE ONCE A MONTH FOR 4 MONTHS OUTCOME WILL BE OBSERVED QAPI. THE DIRECTOR OF NURSIOR DESIGNEE WILL BE RESPONFOR COMPLIANCE BY JULY 5, 20	ALL ATION ATED AT NG ISIBLE	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	transfers, and toile indicated R1 had of TBI. The goals dir needs, and staff a decision-making. risk initiated 10/18 elopement related wanting to leave, sunescorted loiterin need for care/supremotional symptor interventions direct and Accutech on I indicated a trial reconducted however on 12/17/18, with Bemidji, Minnesot During the facility to have 3 floors with not secured. In adobserved to be divunits. The facility of Wanderguard Systo use battery operesidents who were elopement. The bewhich sounds an anear proximity to a prevent residents third floor had a sean Accutech system was similar however, the Acculocked the unit doresident was near Accutech system.	independent with ambulation, eting. The care plan also cognitive impairment related to ected staff to anticipate his long with guardian to assist in The care plan for elopement 1/18, indicated R1 was at risk for to "making statements as sufficient mobility to exit ng near exits; unawareness of ervision due to cognitive and ms". The associated eted staff to apply Wanderguard eft wrist. The care plan also moval of the devices was er, R1 eloped from the facility the intention of walking to	F6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245223	B. WING				C 07/2019	
	PROVIDER OR SUPPLIER  W NURSING & REHA	BILITATION CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 112 WEST FOURTH STREET ED WING, MN 55066	06/07/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 689	the facility. R1 resides semi-secured unit.  R1's Elopement Rist 12/10/18, indicated history of elopement demonstrated curred Wanderguard and R1's progress note indicated R1 was shighway 61, the ad 911 was called. The progress note indicated R1 mas called. The progress note indicated R1 mas found R1. The note to R1 being found and initiated. At 12:24 prote indicated the progress note indicated the progress note indicated the progress note indicated the progress note indicated the process in the facility at 11:45 a.m. documented 12/17/1 had again left the face was following him, facility with the help note dated 12/17/1 had placed a Wand However, the Accurplace.  R1's physician progress included: "He [R1] cognitive deficits are reduced safety awa 24 hour supervision discharge from the confirmed this, and	ded on the 3rd floor  sk Assessment dated since R1 did not have a nt attempts, and hadn't ent elopement behaviors, the Accutech were removed.  dated 12/17/18, at 8:15 a.m. potted walking west on ministrator was notified, and at same day at 10:38 a.m., a eated the police had still not e further indicated events prior on the highway included: R1 as going to go smoke outside ent to give R1 medications, R1 a facility wide search was o.m. on 12/17/18, the progress oblice had returned R1 to the n. A subsequent progress note /18 at 1:36 p.m., indicated R1 acility however, a staff member and R1 was returned to the of the police. The progress 8 at 3:34 p.m., indicated staff derguard on R1's left wrist. tech system was not put in  gress note dated 2/12/19, continues to have severe and physical limitations, has areness and will likely require in when he is ready to facility. Neuro-psych testing advised for a guardian." The R1 was unaware of deficits,	F6	689				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245223	B. WING				C 07/2019	
	PROVIDER OR SUPPLIER W NURSING & REHA	ABILITATION CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 412 WEST FOURTH STREET RED WING, MN 55066	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 689	had poor judgmer R1's physician pro indicated the eval 2/12/19, and now alcohol regularly," go home. R1's progress not did not need to be unit and was allow courtyard to smok R1's Elopement R included R1 was a assessment indica Wanderguard hac out/eloped from th effort to return hor way because he w attempted to hitch R1 had talked abor home. The enviro the facility was ne and hills, and india grounds. R1's social service at 12:18 p.m. inclu he plans on leavir 0500 [5:00 a.m.]. station "in the citie was explained to send meds or pre	orgress note dated 3/22/19, uations from the physician visit included, "Patient has used and was insistent he needed to de dated 3/22/19, indicated R1 escorted off the semi-secured wed to go out to the secured de on his own.  Ask Assessment dated 3/29/19, at risk for elopement. The dated after the Accutech and defacility on 12/17/18, in an one, which placed R1 in harm's walked on a highway, and whike. The assessment indicated but leaving the facility to go onmental risk section indicated are a busy street near woods cated water was on the despendent of the busy of AMA tomorrow (4/10/19) at this plans are to get to the busy and take that to Bemidji. It him that this facility is not able to scriptions with him."	F6	889				

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		A. BUILDI		(X3) DATE SURVEY COMPLETED C				
		245223	B. WING				07/2019	
	PROVIDER OR SUPPLIER W NURSING & REHA	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 1412 WEST FOURTH STREET RED WING, MN 55066					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	R1's progress note included, "Residen (9:50 a.m.)." The re R1 had significant required 24-hour significant a form to make the facility AMA to left the facility. (Ac Weather Service re temperature was 3 degrees).  The Facility Release Discharge form daincluded, "This is to a resident at Bayvice.	dated 4/10/19, at 10:38 a.m. t left facility on AMA at 0950 ecord indicated even though cognitive impairment and upervision, the facility provided the medical decision to leave which R1 signed the form and cording to the National ecords, on 4/10/19, the high 6 degrees with a low of 34 see for Responsibility For ted 4/10/19, at 9:40 a.m. o certify that I, [resident name], ew Nursing and Rehab, am	F6	89				
	physician [physicia home administration management of the personnel and the responsibility for ar in condition, or acc such." The form was practical nurse (LP	,						
	p.m., a family mem hours after R1 had left AMA. The note subsequently called not documented, in hospital drinking coindicated a different inquiring why the fathe facility. The proexplained to the fall explained the risks	is indicated on 4/10/19 at 1:23 aber was notified (nearly 3.5 left the facility AMA), R1 had as indicated R1 had at the facility, time of call was aforming staff he was at the offee. A note at 2:35 p.m., at family member had called acility had allowed R1 to leave agress note indicated it was mily member the facility had and benefits to R1 about d still made the decision to						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245223	B. WING		06	C / <b>07/2019</b>	
	PROVIDER OR SUPPLIE W NURSING & REH	R ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 1412 WEST FOURTH STREET RED WING, MN 55066		70172010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	previously been to emergency guard have record of the was then provide guardianship door emergency guard members as of the manage his own own decisions.  A progress note of indicated the resist by the police 8 how The note also indicated the resist by the police 8 how The note also indicated 4/16/19, the call the police degree R1's physician visit of included the afore physician's visit 3 continued to utilizate home.  R1's progress note of indicated R1 had nursing unit at 10 slurred speech, a like Vodka. The model of the police	then indicated the facility had unaware a court had awarded dianship to the family, and did not e court ordered judgment, which d to the facility. The court nument dated 1/31/19, indicated dianship was granted to family hat date because R1 could not care and could not make his dated 4/10/19 at 5:49 p.m., dent was returned to the facility purs after he'd left the facility. Dicated upon R1's return, a vice was applied to his left wrist. Fare plan had an intervention hat directed staff to immediately partment if R1 left the facility. Seit notes from a 4/22/19 visit, rementioned evaluations from the 1/22/19, and indicated R1 re alcohol and insist on returning the dated 5/5/19, at 1:27 a.m. been observed on the 1st floor 1:15 p.m. with an unsteady gait, and a cup of juice that smelled note indicated R1 was assisted to note dated 5/23/19, indicated R1 galcohol several times over the seit note dated 5/14/19, continued resistent alcohol use and	Fé	589			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION  NG		COMI	E SURVEY PLETED
		245223	B. WING		_	06/0	) 0 <b>7/2019</b>
	PROVIDER OR SUPPLIER  N NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STAT 1412 WEST FOURTH STREE RED WING, MN 55066		, 00,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 689	indicated R1 had p was sent to the em evaluation The notal 2:27 a.m. on 5/2. A progress note daincluded "Resident Wanderguard. New R1's treatment admidirected staff to che every shift and directed staff to check placement a checked marked be the Wanderguard vand function as directed between 5/24/19, a Wanderguard had emergency room 5 A progress note daindicated R1 was odrunk, laying on the room. The note indupstairs to his unit Further, the note in aggressive with the of the facility by the facility on 6/2/19, a Paragressive with the of the facility on 6/2/19, a Paragressive with the of the facility on 6/2/19, a Paragressive with the of the facility on 6/2/19, a Paragressive with the of the facility on 6/2/19, a Paragressive with the facility on 6/2/19, a Pa	s from 5/23/19, at 6:11 p.m. ain in his right shoulder and ergency room for further te indicated R1 had returned 4/19.  Ited 5/30/19, at 4:01 p.m. stated the ER cut off his Wanderguard placed."  Ininistration record (TAR) eck Wanderguard placement cted the night shift staff to not function. The TAR had exes with initials that indicated was checked for placement ected on all days and shifts not 5/30/19, even though the been removed in the 1/23/19.  Ited 6/1/19, at 10:22 p.m. In the 2nd floor of facility, at floor of another resident's icated R1 had refused to go so the police were called. It dicated R1 became physically a officer, and was escorted out officer. R1 returned to the	F6	89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	COM	E SURVEY PLETED
		245223	B. WING				C 0 <b>7/2019</b>
	PROVIDER OR SUPPLIER  N NURSING & REHA	BILITATION CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	reported that the paconsistently consult weeks but they we obtaining it. The visiblood alcohol level R1 was discharged monitoring with no R1's Incident Repoperation. Indicated R1 winfluence of alcohologacility and was pictaken to the emerging The report indicated was contacted in refacility, and the interpretation to re-indicated R1 had a door to smoke, stab brought R1 to the resident of the family was contacted the Accute given orders to hologiven orders to hol	eated the police department atient (R1) had been ming alcohol for the past six re unsure how he was sit note also included R1's was high.The note indicated back to the facility for	F6	i89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245223	B. WING _		06	C 5 <b>/07/2019</b>	
	PROVIDER OR SUPPLIER W NURSING & REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1412 WEST FOURTH STREET RED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	Our staff member well also went. On was able to be cal the resident did gemember calmed he report was submit.  During an interview director of nursing intoxicated and accentrance when he DON stated R1 mi where the smoking staff had witnesse assisted R1 to the area.  During an interview administrator state phone call from the them R1 had elops stumbling on the staff were to alert count could be conadministrator state staff were to alert count could be conadministrator state staff were expected police.  During an interview police Sargent from at the facility to disstated R1 had been the street downtow and stated	who got along with the resident ce they got there the resident med down. Later about 11 p.m., at worked up again and the staff im down". A vulnerable adult ted to the State Agency.  W on 6/3/19, at 5:15 p.m. the (DON) stated R1 had been tivated the alarm on the main walked out to smoke. The ight have been confused as to g area was. The DON stated d, immediately responded, and secured designated smoking  W on 6/3/19, at 7:55 p.m. the ed the facility had received a epolice department informing ed from the facility, was found threet, and had been taken to administrator stated when the m sounded, all staff were pond and look outside. The ed if a resident was not seen, the charge nurse so a head impleted. In addition, the ed if a resident was not found, id to immediately notify the  W on 6/3/19, at 8:32 p.m. a m the police department arrived is a resident was not found, id to immediately notify the in wandering in the middle of whom Main Street (highway 61), it become disorderly, was is, then transported to the	F 68	9			

NAME OF PROVIDER OR SUPPLIER  BAY VIEW NURSING & REHABILITATION CENTER    X41   ID   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   TAG		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
MAME OF PROVIDER OR SUPPLIER  BAY VIEW NURSING & REHABILITATION CENTER    X41   ID   PREFIX TAG   TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 689   Continued From page 11 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 call to dispatch came in at 7:34 p.m. 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 the 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.			245223	B. WING_		06	C /07/2019	
F 689  Continued From page 11 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 call to dispatch came in at 7:34 p.m. PO-A stated the 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.					1412 WEST FOURTH STREET			
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.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE	
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	F 689	During an interview officer (PO)-A arriv R1 "was staggering first spotted on the Main, walked down and Bush, a group him to the sidewall was close to a mile the call to dispatch stated when he arridentified by the nat Wanderguard brach had a strong smell administered the ahowever R1 instead and ministered the ahowever R1 instead and was placed in called, and R1 was PO-A stated R1 retransfer, and remate to the hospital for a duration R1 was in 30 minutes.  During an interview nursing assistant (to freely move abound staff were not he would leave his who have Wanders.	on 6/3/19, at 8:38 p.m. police red at the facility. PO-A stated g in the middle of Main Street, intersection of Plumb and to the intersection of Main of citizens successfully got k." PO-A stated the location from the facility. PO-A stated came in at 7:34 p.m. PO-A sived on the scene, R1 was only me on his socks, had a relet on, was mumbling, and of alcohol. PO-A stated he lohol breathalyzer test, d of blowing, spit into the lohol breathalyzer test, d of blowing, spit into the lohol breathalyzer test, d as level. PO-A stated R1 reported ad been drinking all day. PO-A call, R1 had become disorderly handcuffs, an ambulance was a transferred to the hospital. In mained in cuffs during the ined in handcuffs after arrival a short time. PO-A stated the handcuffs was approximately on 6/4/19, at 7:45 a.m. NA)-C stated R1 was allowed ut the building without escort, instructed to watch R1 when unit.NA-C stated residents guards or Accutechs were		39			

I ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING				C <b>07/2019</b>
	PROVIDER OR SUPPLIER  N NURSING & REHA	L		STREET ADDRESS, CITY, STATE, 1412 WEST FOURTH STREET RED WING, MN 55066		1 00/	0112013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 689	type of system. NA: at the nurse's static in addition to the au were to check the of the alarm, look outs visible, the charge head count perform. During an interview licensed practical in Wanderguard on. L started drinking alcaware of two episor intoxicated. LPN-A a plan for alcohol u she had last seen f when he left the un intoxication. LPN-A Wanderguard on, we facility independent unit more than he we R1 would tell staff in however, this was in nursing stations for stated once R1 was responsibility of the units to supervise he staff's responsibility. Wanderguard alarm resident was not for was performed.  Also during the interpretation of the building. LPN-A facility on 4/10/19, I of his intentions; stated	e sound dependent on the C indicated there was a panel on that would display a red light adible alarm. NA-C stated staff doors, enter the code to silence side, and if a resident was not nurse was to be notified, and a ned.  Ton 6/4/19, at 8:00 a.m.  To	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING				C <b>07/2019</b>
	PROVIDER OR SUPPLIER  N NURSING & REHA	ABILITATION CENTER	,	1412 W	FADDRESS, CITY, STATE, ZIP CODE VEST FOURTH STREET VING, MN 55066	, 33.	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	the form to her, and the form with R1. If facility on foot. LPI facility was not aw and thought R1 was make decisions. Let that time whether aware R1 had left she was unaware dated 12/12/18, the cognitive impairmed aware of the guard not been allowed to been followed, and contacted.  During an interview nursing assistant (perspective. NA-Afacility on 4/10/19, days he was going stated during that and would tell him stated R1 left the factorial was not aware of the impairment, per the indicated R1 had contacted R	he social worker had provided and further stated she went over LPN-A stated R1 then left the N-A stated at the time the are of the guardianship order, as his own person who could PN-A stated she was unsure at the physician had been made the facility AMA. LPN- A stated of the neuropsych examination at indicated R1 had severe ent. LPN-A stated had she been dianship order, R1 would have to leave AMA, he would have to leave AMA, he would have to leave AMA, he would have to leave the facility. NA-A stated prior to R1 leaving the he had told staff for several to leave the facility. NA-A time staff would redirect R1, it was not a good idea. NA-A facility AMA on the morning of several layers of clothes. NA-A che level of R1's cognitive eneuropsych exam. NA-A called the facility several times his locations to staff and was the facility by the police further stated R1 had a was able to walk around the ently without escort, and spent ently without escort ently	F6	89			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING				C <b>07/2019</b>
	PROVIDER OR SUPPLIER  N NURSING & REHA	BILITATION CENTER		ST 14	REET ADDRESS, CITY, STATE, ZIP CODE 12 WEST FOURTH STREET ED WING, MN 55066	1 06/	0772019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	stations when R1 le Wanderguards were every shift, and che shift. NA-A verified door alarm were to outside, if resident nurse was notified,  During an interview restorative nursing had been drinking a weeks. RNA-A indiwhether R1 had an stated he had sper R2 had been drinki almost daily he was further stated an urresponsibility it was off the unit; stated the receptionist "kir During an interview stated R1 frequent home more on the day shift. NA-B stated was able to maindependently. NA-was going downstated it was not constations when R1 werified it was facili went off, all staff were spond and check resident was not for be done.  During an interview stated R1 had a Westated R1 had a Westa	eaves the unit. NA-A stated the re checked for placement ecked for function every night facility protocol indicated if a go off, staff were to look was not seen, the charge and a head count done.  You 6/4/19, at 8:34 a.m. assistant (RNA)-A stated R1 a lot during the last couple of cated an unawareness of ything to drink on 6/3/19, but at a lot of time in R2's room and ng. RNA-A stated R1 stated need to go home. RNA-A nawareness of whose to supervise R1 once he was "we all kind of do" and thought nd of knew what is going on".  You 6/4/19, at 8:42 a.m. NA-B by stated he wanted to go evening shift than during the ted R1 had a Wanderguard on ove about the facility. B stated R1 told staff when he have continued to other nursing would leave the unit. NA-B also ty protocol if the Wanderguard ere responsible to immediately a outside. NA-B said if a und, a head count needed to a cility independently. LPN-B anderguard on but was able to acility independently. LPN-B	F6	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING	i	06	C 5 <b>/07/2019</b>	
	PROVIDER OR SUPPLIE W NURSING & REH	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 1412 WEST FOURTH STREET RED WING, MN 55066		70172010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	had been good in in the afternoon, home. LPN-B stanotified the adminand was not sure LPN-B indicated responded to a V found R1 outside cigarette. LPN-B out the wrong do under the influen R1 was more diff she'd assisted R and notified the a worked until 6:00 not given any oth LPN-B stated whevening, R1 was During an intervielicensed social w stated an unawar the facility were of the facility had justicensed there had place from the last been working on more comprehen	orked on 6/3/19 and stated R1 in the morning, had some alcohol and had been stating he missed ited around 3:30 p.m., she had histration R1 had been drinking is how he obtained the alcohol. around 4:00 p.m. she had wanderguard alarm and had it he main entrance smoking a stated she thought R1 had gone for to smoke because he was ce. LPN-B indicated on that day, icult to redirect than usual, but it to the enclosed smoking area, idministrator. LPN-B stated she p.m. and after the incident was er direction pertaining to R1. en she left the building that	F	589			
	LPN-C also state implemented a no and there had be ensuring resident	ew on 6/4/19, at 11:51 a.m. d the facility had just ew alcohol policy "today" 6/4/19, en some confusion about t rights to drink alcohol that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245223	B. WING			C <b>07/2019</b>
	PROVIDER OR SUPPLIER  N NURSING & REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 740 SS=D	The facility was not Jeopardy for R1 or was removed on 6 facility had provide and the plan could including: All reside checked and accorpolicy and proceed developed and imalcohol use were developed and substance use mental well-being, in accordance assessment and pencompasses a remental well-being, limited to, the prevand substance use This REQUIREMED by:  Based on interviet failed to provide in services related to	drinking alcohol however, was obtained it.  Diffied of the Immediate in 6/4/19, at 5:15 p.m. The IJ 6/5/19, at 4:33 p.m. when the ed an acceptable removal plan, if the verified as implemented lents with security devices were bunted for; A comprehensive lure for elopement was plemented; Guidelines for developed; All staff were vised facility policies and were were to implement, including openent and alcohol use method of auditing to ensure ce was developed and initiated. Services  all health services. Set receive and the facility must sary behavioral health care and for maintain the highest all, mental, and psychosocial ordance with the comprehensive plan of care. Behavioral health esident's whole emotional and which includes, but is not vention and treatment of mental	F 7		OHOL PER	7/3/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING				C 07/2019
NAME OF I	PROVIDER OR SUPPLIEF	₹	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	7172010
				1	412 WEST FOURTH STREET		
BAY VIE	W NURSING & REH	ABILITATION CENTER		R	RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	assessment dated independent with ambulation on and supervision with hR1 had exhibited days during the as R1's admission rediffuse traumatic hand anxiety disord R1's care plan did to alcohol use.  R1's progress not On 6/3/19, a note indicated earlier in the influence of al facility. The note in in the middle of a were called to corbehaviors. R1 had the emergency roaggressive behav On 6/1/19, at 10:2 included: "Writer facility unit] as [R1 in room [number]. going to call the pupstairs and pulle	imum Data Set (MDS) d 3/29/19 indicated R1 was transfers, was independent with d off the units, and required ygiene. The MDS also indicated rejection of care behaviors 1-3 ssessment period.  cord, included diagnoses of orain injury (TBI), alcohol abuse, der.  not include information related  es reviewed included: documented at 11:39 p.m. in the shift, R1 had been under cohol and had eloped from the idicated R1 ended up downtown traffic intersection and police itain him due to erratic d to be restrained and taken to form (ER) due to escalating iors. 2 p.m. a progress note was called down to 2W [a ] was drunk laying on the floor He got up after I told him I was olice. He refused to come d away from staff. He went	F 7	740	GUIDELINES. R1'S CAREPLAN REVIEWED AND REVISED.  R2 IS TRIALING AN ALCOHOL CONSUMPTION PROGRAM BASIPHYSICIAN ORDERS AND ALCOIGUIDELINES. R2'S CARE PLAN REVIEWED AND REVISED.  R6 IS NO LONGER DRINKING ALCOHOL PER PHYSICIANS ORIAND ALCOHOL GUIDELINES. R6'CARE PLAN REVIEWED AND STAFF AREAS ALCOHOL / SUBSTANCE GUIDEL ON 6/4/2019 AND DISPERSED TO A RESIDENTS. POLICY UPDATED 6/20/2019 AND DISPERSED TO A RESIDENTS AND STAFF AREAS REVIEW ON 6/21/2019.  EDUCATION PROVIDED TO ALL PERTAINING TO THE RESIDENT ALCOHOL/SUBSTANCE GUIDELI STARTING 6/4/2019. REVIEW EDUCATION PROVIDED REVIEW EDUCATION PROVIDED REVIEW EDUCATION PROVIDED.	DER S VISED.  E A  FOR  DENT LINES D'ALL  LL FOR  STAFF  NES	
	see if they could g his room. He walk	ng patio. Police were called to pet him to comply with going to ed upstairs with officer. He at the aggressive toward the police.			JULY MONTHLY MEETINGS.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245223	B. WING			C 07/2019
	PROVIDER OR SUPPLIER W NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 1412 WEST FOURTH STREET RED WING, MN 55066	· · · · · · · · · · · · · · · · · · ·	0172013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 740	and they took him R1 incident note da "was reported to be this shift, [R1] spok [a staff name]. [R1 facility and was pict to the ER no injurie (message) left for report done with Ac According to R2's the facility on 7/23/ of abnormality of gadjustment disorder R2's care plan incluments and the facility and impure suasive [sic] dis AEB risk-taking be aggressiveness, concervious alcohol us behavior current al Date Initiated 4/21/ monitor for signs of and behavior chan approach with calmof eye contact, mato two sets of vital intoxicated. R2's conformation about and failed to include storage of alcohol. Information about salcohol abuse or be service involvements.	ated on 6/3/19, at 9:23 p.m. ated on 6/3/19, at 9:23 p.m. at under the influence of alcohol cen to by staff and supervisor, continued to drink then left ked up by the police and taken as reported to staff. Msg family about incident police dm (administrator) [name]."  Face sheet, R2 was admitted to 18, with an admitting diagnosis ait, history of seizures, ar and alcohol dependence.  Face and impulsive, explosive cohol use within the facility. In the rentions included: f intoxication, be alert for mood ges, use a kind and firm a voice, therapeutic touch, use ke 30 minute checks, and one signs if R2 appears are plan did not include R2 drinking with other residents a directions related to safe R2's care plan did not include services to provide related to ehavioral health or social	F 740	AND WILL BE COMPLETE RESIDENT BY JULY 5, 20° QUARTERLY.  AUDIT 24-72 HOUR REPO ALCOHOL USE-INTOXICA BEHAVIORS ONCE A WEE WEEKS AND ONCE A MOI MONTHS.  OUTCOME WILL BE OBSE QAPI. DIRECTOR OF NUE DESIGNEE WILL BE RESE COMPLIANCE BY 7/5/2019	PONIBLE FOR	
		dated on 6/2/19, at 12:43				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C	
		245223	B. WING			) 07/2019
	PROVIDER OR SUPPLIER W NURSING & REH	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 1412 WEST FOURTH STREET RED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 740	staff had difficulty indicated staff had the physician of hi and disposed of o of vodka from R2's According to R6's admitted to facility diagnosis of repeathrive, and with a dabuse.  R6's care plan inc "I am adjusting ok a history of alcohol trying to bring me cannot have alcohog/28/2018." Interchanges in accept R6's care plan fail how to care for R6 how to deal with is facility, or how to pof alcohol misuse. indicate any referrof alcohol.  According to R6's on his floor 5/23/1 had an abrasion of eyebrow. A prior palso indicated R6 smelling of alcohol.  During an interview restorative nursing had been drinking weeks. RNA-A sai	rousing the resident. The note I taken vitals and later notified s condition. Staff also found pen, partially consumed bottles	F 741			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245223	B. WING _			C / <b>07/2019</b>
	PROVIDER OR SUPPLIER  W NURSING & REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 740	Continued From p	age 20	F 74	0		
	unawareness of w supervise R1 once "we all kind of do."  During an interview licensed practical been working on 6 stated R1 had con afternoon, and she around 3:30 p.m. a sure how he had co said she'd found R smoking a cigarett thought he had go smoke because he alcohol. LPN-B state to redirect than us	go home. RNA-A stated an hose responsibility it was to he he was off the unit by saying, whom on 6/4/19, at 8:58 a.m. hourse (LPN)-B stated she had be a had notified the administration about R1's drinking but was not obtained the alcohol. LPN-B at outside the main entrance around 4:00 p.m., and the out the wrong door to be was under the influence of ated R1 had been more difficult ual, but she had assisted R1 to king area and had notified the				
	stated he kept alco supply it to R1. R2 his own through lo drink whiskey. R2 alcohol in Gatorad had been drinking would come to his stated over the we and ended up hittin of the head after we and removed from According to an in LPN-D said the fact assessment to be abuse upon admis	ov on 6/4/19, at 10:15 a.m. R2 chol in his room but did not a stated R1 obtained alcohol on cal friends and that R1 liked to stated R1 would disguise the e bottles. R2 further stated R1 a lot the last few weeks and room and drink socially. R2 sekend, R1 was really drunk, and a police officer over the top which R1 was put in handcuffs a the facility.  terview on 6/4/19 at 8:23 a.m., cility did not have a resident used related to substance sion to the facility. LPN-D wit was explained to me,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING		_	C 5/07/2019
	PROVIDER OR SUPPLIER  N NURSING & REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STA 1412 WEST FOURTH STRE RED WING, MN 55066	TE, ZIP CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 740	stuff. Prior to that tup the pieces and Just putting things we had someone is bottle of booze. It's [Administrator] we past the ombudsm we believe they ar call the doctor first last administrator if feel good. He pretithey wanted. It was a sudden it seems alcohol." LPN-D fustate to one anothing tit this weekend been aware of a pubstance use in tweeks and had be that time, but it had a new policy in rights because this consider the problespace. I wish I'd hay esterday. We have last month. I got the and sent it to the can't just pull the arrooms. This is the like that. Some of drinking at home a	age 21 ation allowed drinking and they didn't. Now it's like we pick try to put them back together. togetherThis past weekend in the entryway with a whole is my understanding of a new policy but has to run it fee under the influence, but we call LPN-D continued, "I think the ust wanted to make everyone try much let everyone do what is not like that before, but all of a dike there was a lot of arther stated residents would feer, "I got it last weekend; you al." LPN-D stated the facility had roblem with alcohol and the building for at least six en working on a policy from donot yet been instituted.  In 6/4/19, at 8:47 a.m. the for stated the facility had a policy regarding resident administrator stated, "We just a place. There are resident as is their home, but we have to gen with disruption in a public and this in place before the been working on this since the peer review done last week around 3 p.m. or so yesterday ombudsman last night We alcohol from their (resident) in home and we want it to feel these people have been and then they come here and "home" all the time, they think	F 7	40		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING		06	C / <b>07/2019</b>	
	PROVIDER OR SUPPLIE W NURSING & REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1412 WEST FOURTH STREET RED WING, MN 55066		70172010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 740	they can just be of say they can't drin is safe." The admissue of safe stor stating, "It's been wanted to store it think we could just we have to have that we will store safe for the other drinking becomes to everyone at the and all residents discovered] will be the safety of resident was a standard a resident was sust alcohol which inversident was a standard as a	drinking here. We don't want to mk, but we need to assure that it ministrator also addressed the age of alcohol within the facility a problem in the past. They in the med cart but we didn't st take people's alcohol like that, a plan. Our policy is going to be it. Then we can make sure it is residents and we can assess if an issue. The policy will go out a same time. All staff will know will know that it [any alcohol be brought to nurse's station for dents-others and themselves." It also stated she thought there is sessment completed if a poected to have been using polved notification of the sessment of vital signs.  Bew on 6/4/19, at 10:36 a.m. borkers (LSW)-A and LSW-B unaware of how many residents at implemented a policy for tion that day (6/4/19). LSW-A anot been a good policy in place of facility owners and the facility gon designing and implementing ensive plan. LSW-A also stated a alcohol should be identified in	F7	40			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
						С
		245223	B. WING		06/	07/2019
	PROVIDER OR SUPPLIEF	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIED TO THE APP		_D BE	(X5) COMPLETION DATE
F 740	be clarified. RN-A	stated an awareness of R1 owever, was not sure, how R1	F 7	740		



Protecting, Maintaining and Improving the Health of All Minnesotans

**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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00149	B. WING		C 06/07/	2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	,	
BAY VIE	W NURSING & REHA	BII ITATION CFN	ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000 Initial Comments			2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the mumber and MN Russian in the pursuant of the number and MN Russian is survey to a survey of the pursuant of the purs	nether a violation has been				
	comply with any of a lack of compliance. re-inspection with a result in the assess	the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a int for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/07/19 **Electronically Signed** 

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION S:		(X3) DATE SURVEY COMPLETED	
		00149	B. WING			C <b>07/2019</b>
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CEN	WEST FOURTH			
0(1) 15	CHMMADV CTA		WING, MN 5506	PROVIDER'S PLAN OF	CORRECTION	()/5)
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2 000	Continued From pa	ge 1	2 000			
	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to element of Minnesota Department's staff complaint H522315	Ith orders being submitted Although no plan of corrected Statutes/Rules, please rected" in the box available indicate in the electronic cess, under the heading e date your orders will be electronically submitting to the health.  6/7/19, surveyors of this conducted an investigation at 0830 (4658.0520 Subp.)	tion for he			
		olaint H5223152C was four th no deficiency cited.	nd to			
	H5223149C, H5223	olaints H5223151C, 3148C, H5223150C, 3154C were unsubstantiate	ed.			
	correction that you	our electronic plan of have reviewed these order e when they will be comple				
	the State Licensing federal software. To assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Statement and replaces the "T correction order. The findings which are in the state of the sta	nent of Health is document Correction Orders using ag numbers have been tota state statutes/rules for umber appears in the far le Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state state, "This Rule is not met as	eft			

Minnesota Department of Health

STATE FORM 6899 RURL11 If continuation sheet 2 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	ATE SURVEY OMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
BAY VIE	W NURSING & REHA	BILLIATION CEN	ST FOURTH G, MN 5506		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	evidence by." Followare the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO RECOPLAN OF CORRECOMINNESOTA STAT	wing the surveyors findings Method of Correction and rection.  RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.  QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF	2 000		
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830		7/7/19
	by: Based on interview failed to identify, co implement interven	ent is not met as evidenced and record review, the facility mplete assessment, tions and provide supervision R1) who consumed alcohol e facility.		R1 WAS FOUND AND BROUGHT TO THE HOSPITAL FOR ASSESSMENT. I INTERNAL OR EXTERNAL INJURIES FROM EVENT. R1'S CAREPLAN REVIEWED AND REVISED. ACCUTER	

Minnesota Department of Health

STATE FORM 6899 RURL11 If continuation sheet 3 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 50.25		С	
		00149	B. WING			7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILLI A LION CEN	ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 3	2 830			
	Findings include: R1's neuropsychiat identified R1's med traumatic brain inju having been hit by a highway intoxicated indicated R1's IQ sand indicated R1 hall n addition, the note court-ordered guard healthcare and final cognitive impairmed would likely require returned to the com	ry visit note dated 12/12/18, ical history included a ry (TBI) as a result of R1 a car when walking along a d. The neuropsychiatry exam core was between 75 and 87, ad reduced safety awareness. e included, "He requires a dian to assist him in making incial decisions due to severe ent." The note also indicated R1 24 hour supervision once he		APPLIED UPON RETURN. ACCUSYSTEM SECURES THE ELEVA AND 3 EAST ENTRANCE.  ALL RESIDENTS HAD THE NEW ELOPEMENT ASSESSMENT COMPLETED ON 6/5/2019.  IMPLEMENTATION OF THE ELOPEMENT BINDER INCLUDIN POLICY ON ELOPEMENT RISK, ON MISSING RESIDENT, CHECIELOPEMENT ASSESSMENT, SELOG, LIST OF CODES, AND SKI ASSESSMENT ON 6/4/2019.  PICTURE OF EACH RESIDENT ELOPEMENT RISK IN eLOPEMENT BINDERS AT EACH UNIT AND A RECEPTION DESK.	NG: POLICY KLIST, EARCH N WITH	
	R1's quarterly Minir assessment dated independent with trambulation on and supervision with hy R1 exhibited rejectiduring the assessment R1's Care Area Assymptoms and Cog 10/18/18, were triggadmission MDS. The completed, how head injury, pain, a others. The Cognitic completed, however triggered because a mood state, behavi	mum Data Set (MDS) 3/29/19, indicated R1 was ansfers, was independent with off the units, and required giene. The MDS also indicated ion of care behaviors 1-3 days nent period.  sessment (CAA) for Behavioral gnitive Loss/Dementia dated gered to be completed by the ne Behavioral assessment was vever identified R1 to have a nd verbal behaviors directed at ve Loss CAA was also not er indicated this CAA was of diagnosis of TBI, assessed oral symptoms, and presence ne MDS during the assessment		EDUCATION WAS PROVIDED T STAFF PERTAINING TO EXPEC FOR ELOPEMENT/ELOPEMENT BINDER STARTING 6/4/2019. RE EDUCATION WILL BE COMPLE JULY MONTHLY MEETINGS. ELOPEMENT DRILL COMPLETE 6/10/2019 AND WILL BE COMPL ONCE A MONTH FOR 4 MONTH OUTCOME WILL BE OBSERVED QAPI. THE DIRECTOR OF NURS DESIGNEE WILL BE RESPONSI FOR COMPLIANCE BY JULY 5, 2	EVIEW TED AT ED ON ETED IS. O AT SING OR BLE	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00149		B. WING			C <b>07/2019</b>
	PROVIDER OR SUPPLIER	1412 WF	DDRESS, CITY, S	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	RED WIN	G, MN 5506	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	period.					
	R1's current care plindicated R1 was in transfers, and toilet indicated R1 had completed the reds, and staff alloweds, and staff alloweds and staff alloweds and related the twanting to leave, such unescorted loitering need for care/super emotional symptom interventions directed and Accutech on leindicated a trial remonducted however	ed staff to apply Wanderguard ft wrist. The care plan also noval of the devices was r, R1 eloped from the facility ne intention of walking to				
	to have 3 floors with not secured. In add observed to be dividuality. The facility exwanderguard Systeto use battery operaresidents who were elopement. The brawhich sounds an aunear proximity to ar prevent residents from third floor had a ser an Accutech system was similar however, the Accut locked the unit door	our, the facility was observed in resident elevators that were lition, the facility was also ded into separate nursing kits were observed to have a sem. The system was identified ated bracelets applied to a determined to be at risk for acclets omit radio waves, udible alarm if the bracelet is in a exit. The system did not some exiting the building. The mi-secured unit which utilized in. Upon review, the Accutech to the Wanderguard system ech system automatically its from both sides when a the unit exit doors. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00149	B. WING			, 7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT	ST FOURTH : G, MN 55060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	0 Continued From page 5					
	doors to the third fle	vas only utilized on the exit oor unit but nowhere else in ded on the 3rd floor				
	12/10/18, indicated history of elopemer demonstrated curre	sk Assessment dated I since R1 did not have a nt attempts, and hadn't ent elopement behaviors, the Accutech were removed.				
	indicated R1 was shighway 61, the ad 911 was called. The progress note indicated R1. The note to R1 being found chad told staff he wand when nurse was not found and initiated. At 12:24 prote indicated the process of the facility at 11:45 a.m. documented 12/17, had again left the facility with the help note dated 12/17/1 had placed a Wand However, the Accuplace.	dated 12/17/18, at 8:15 a.m. potted walking west on ministrator was notified, and at same day at 10:38 a.m., a cated the police had still not e further indicated events prior on the highway included: R1 as going to go smoke outside ent to give R1 medications, R1 a facility wide search was o.m. on 12/17/18, the progress colice had returned R1 to the n. A subsequent progress note /18 at 1:36 p.m., indicated R1 acility however, a staff member and R1 was returned to the of the police. The progress 8 at 3:34 p.m., indicated staff derguard on R1's left wrist. tech system was not put in				
	included: "He [R1] cognitive deficits ar reduced safety awa 24 hour supervision discharge from the	gress note dated 2/12/19, continues to have severe nd physical limitations, has areness and will likely require n when he is ready to facility. Neuro-psych testing I advised for a guardian." The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			7. BOILDING.	·		
		00149	B. WING			7/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BAY VIEW NURSING & REHABILITATION CEN			ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 6	2 830			
	note also indicated R1 was unaware of deficits, had poor judgment, and requested to go home.					
	indicated the evaluation 2/12/19, and now in	gress note dated 3/22/19, ations from the physician visit ncluded, "Patient has used and was insistent he needed to				
	did not need to be	dated 3/22/19, indicated R1 escorted off the semi-secured ed to go out to the secured 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.					
	at 12:18 p.m. include he plans on leaving 0500 [5:00 a.m.]. H station "in the cities	s progress note dated 4/9/19 ded, "Resident let writer know g AMA tomorrow (4/10/19) at is plans are to get to the bus " and take that to Bemidji. It m that this facility is not able to criptions with him."				
		evidence R1's family ohysician were notified of R1's cility.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
				A. BUILDING:			_
		00149		B. WING			C 0 <b>7/2019</b>
NAME OF	PROVIDER OR SUPPLIER	Sī	TREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CENT		T FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	R1's progress note included, "Resident (9:50 a.m.)." The re R1 had significant or required 24-hour st R1 a form to make the facility AMA to left the facility. (Ac Weather Service re temperature was 3 degrees).  The Facility Releas Discharge form dat included, "This is to a resident at Bayviel leaving against the physician [physician home administration management of the personnel and the responsibility for ar deterioration in con result from such." The and licensed praction of the personnel and the responsibility for an esterioration in contesult from such." The progress note p.m., a family mem hours after R1 had left AMA. The notes subsequently called not documented, in hospital drinking coindicated a different inquiring why the fatthe facility. The professioned to the far explained the risks leaving, and R1 had	dated 4/10/19, at 10:38 t left facility on AMA at 0 ecord indicated even the cognitive impairment an upervision, the facility prothem edical decision to which R1 signed the forecording to the National ecords, on 4/10/19, the reference with a low of the forecording to the National ecords, on 4/10/19, at 9:40 a.m. of certify that I, [resident of the Working and Rehab, advice of the attending in name], and of the nurse, and absolve the esaid care facility, it's attending physician of any ill effects or any indition, or accident which the form was signed by cal nurse (LPN)-A.  Is indicated on 4/10/19 and the facility AMA), Railer was notified (nearly left the facility AMA).	optopication of the control of the c	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			C	
		00149	B. WING			07/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BAY VIE	W NURSING & REHA	BILLIATION CEN	ST FOURTH G, MN 5506				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 830	emergency guardia have record of the was then provided guardianship docur emergency guardia members as of that manage his own carown decisions.  A progress note daindicated the reside by the police 8 hour The note also indic Wanderguard device R1's elopement caradded 4/16/19, that call the police depart R1's physician visit included the aforem physician's visit 3/2 continued to utilize home.  R1's progress note indicated R1 had be nursing unit at 10:1 slurred speech, and like Vodka. The not bed. A progress not had been drinking a weekend.	aware a court had awarded anship to the family, and did not court ordered judgment, which to the facility. The court ment dated 1/31/19, indicated anship was granted to family the date because R1 could not are and could not make his are and could not his left wrist.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at directed staff to immediately artment if R1 left the facility.  The plan had an intervention at the facility at th					
	R1's progress note	s from 5/23/10 at 6:11 n m					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00149	B. WING			C <b>07/2019</b>
	PROVIDER OR SUPPLIER W NURSING & REHA	BILITATION CEN. 1412 WE	DDRESS, CITY, S ST FOURTH S IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	indicated R1 had pay was sent to the emercy evaluation. The no at 2:27 a.m. on 5/24  A progress note daincluded "Resident Wanderguard. New R1's treatment admidirected staff to cheevery shift and directed placement at checked marked by the Wanderguard wand function as directed to the wanderguard w	ain in his right shoulder and ergency room for further te indicated R1 had returned 4/19.  ted 5/30/19, at 4:01 p.m. stated the ER cut off his Wanderguard placed."  Ainistration record (TAR) eck Wanderguard placement cted the night shift staff to and function. The TAR had exes with initials that indicated was checked for placement ected on all days and shifts and 5/30/19, even though the peen removed in the	2 830			
	indicated R1 was o drunk, laying on the room. The note indicated R1 was in upstairs to his unit is Further, the note in aggressive with the of the facility by the facility on 6/2/19, at An emergency roor indicated R1 had a related to TBI and remergency room vialcohol intoxication patient states he had tonight and was a control of the note also indicated that the part of the note in the	ted 6/1/19, at 10:22 p.m. In the 2nd floor of facility, It floor of another resident's It floor of another resident of another resented to the It floor of a police for evaluation of It floor of a police for evaluation of a police for him". It floor of another resident's It floor of another resident'				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		LLILD	
		00149	B. WING			C <b>07/2019</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
<b>5</b> 43737		1412 W	EST FOURTH	STREET			
BAY VIE	W NURSING & REHA	BILITATION CEN RED WI	NG, MN 5506	6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
2 830	Continued From pa	age 10	2 830				
2 000	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.		2 000				
	p.m. indicated R1 v influence of alcohol facility and was pick taken to the emerg The report indicate was contacted in refacility, and the inte the decision to re-in	rt note dated 6/3/19, at 9:23 was reported to be under the I, continued to drink, left the ked up by the police, and was ency room with no injuries. d at 9:50 p.m., the physician egards to R1 leaving the erdisciplinary team had made implement the Accutech mily responded to phone calls					
	indicated R1 had activate the Accute given orders to hold further included, "P stating that our resist they were bringing stated that the reside attention on a stretched when he arrived at calm down. Reside act up. Police were Our staff member well also went. Once was able to be calm door to staff member was able to be calm door to staff member was able to be calm door to the residence of the staff member was able to be calm door to staff member was able to be calm.	dated 6/3/19, at 11:39 p.m. ccidentally gone out the wrong fir had seen this happen and ight area. The note indicated tacted with a request to each system, and the MD had drisk medications. The note folice officer called the facility ident was found downtown and him to the hospital. Officer dent was found down by main lerly. The police officer went to the tesident acted like he we. The resident was ven to the ER (emergency the hospital. Resident did ent out of no where started to e called back to the hospital. who got along with the resident med down. Later about 11 lid get worked up again and	d				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		00149	B. WING		<b>I</b>	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CEN.	T FOURTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	vulnerable adult rep Agency.  During an interview director of nursing intoxicated and act entrance when he van DON stated R1 mig where the smoking staff had witnessed assisted R1 to the state of the call from the difference and interview administrator stated phone call from the state of the hospital. The act Wanderguard alarm responsible to resp	almed him down". A cort was submitted to the State of on 6/3/19, at 5:15 p.m. the (DON) stated R1 had been ivated the alarm on the main walked out to smoke. The ght have been confused as to area was. The DON stated It, immediately responded, and secured designated smoking of on 6/3/19, at 7:55 p.m. the did the facility had received a expolice department informing did from the facility, was found the reet, and had been taken to diministrator stated when the misounded, all staff were found and look outside. The				
	administrator stated staff were to alert the count could be come administrator stated staff were expected police.  During an interview police sergeant from arrived at the facilit sergeant stated R1 middle of the street (highway 61), and stated disorderly, was place transported to the highway for the street of	d if a resident was not seen, he charge nurse so a head hpleted. In addition, the d if a resident was not found, d to immediately notify the on 6/3/19, at 8:32 p.m. a m the police department y to discuss R1's event. The had been wandering in the todowntown on Main Street stated R1 had become ced in handcuffs, then nospital by ambulance.				
		ed at the facility. PO-A stated				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′			LETED
			"			,
		00149	B. WING		06/0	, 7/2019
		00149			1 06/0	112019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RAY VIF	W NURSING & REHA	BILITATION CEN. 1412 WES	ST FOURTH S	STREET		
DAT VIL	W NOROMO & NEMA	RED WIN	G, MN 55066	3		
(X4) ID	=	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5) COMPLETE
PREFIX TAG	<b>`</b>	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 830	Continued From pa	ge 12	2 830			
	•					
		in the middle of Main Street, intersection of Plumb and				
		to the intersection of Main				
		of citizens successfully got				
		." PO-A stated the location				
	was close to a mile	from the facility. PO-A stated				
		came in at 7:34 p.m. PO-A				
		ved on the scene, R1 was only				
		me on his socks, had a				
		elet on, was mumbling, and of alcohol. PO-A stated he				
		cohol breathalyzer test,				
		d of blowing, spit into the				
		ts were .032. The PO-A stated				
	from his experience	e that reading would result in a				
		evel. PO-A stated R1 reported				
		ad been drinking all day. PO-A				
		call, R1 had become disorderly				
		nandcuffs, an ambulance was transferred to the hospital.				
		nained in cuffs during the				
		ned in handcuffs after arrival				
	1	short time. PO-A stated the				
	-	handcuffs was approximately				
	30 minutes.					
	During an internal	on 6/4/10 ct 7:45 c				
		on 6/4/19, at 7:45 a.m. NA)-C stated R1 was allowed				
		it the building without escort,				
	,	nstructed to watch R1 when				
		unit. NA-C stated residents				
		juard's or Accutechs were				
	identified on "Care	Cards". NA-C stated there				
		m on both the exits to the				
		ne door alarms all sounded the				
		e sound dependent on the				
		-C indicated there was a panel				
		on that would display a red light udible alarm. NA-C stated staff				
		loors, enter the code to silence				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00149	B. WING		1	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CEN	ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	the alarm, look outs visible, the charge head count perform.  During an interview licensed practical in Wanderguard on. I started drinking alcaware of two episorintoxicated. LPN-A a plan for alcohol ushe had last seen for when he left the unintoxication. LPN-A Wanderguard on, when the left the unintoxication. LPN-A wanderguard on, when the left the unintoxication was responsibility independent unit more than he was nursing stations for stated once R1 was responsibility of the units to supervise his taff's responsibility Wanderguard alarm resident was not for was performed.  Also during the interpolation was performed. LPN-A provided his the building. LPN-A state morning and the form to her, and the form with R1. Lefacility on foot. LPN facility was not away was not a	side, and if a resident was not nurse was to be notified, and a ned.  on 6/4/19, at 8:00 a.m. nurse (LPN)-A stated R1 had a LPN-A stated R1 had recently ohol and stated she was des when R1 had become verified R1's care plan lacked se. LPN-A stated on 6/3/19, R1 at approximately 1:30 p.m. it, and did not note his a stated R1 had a was free to move around the ty, and stated R1 was off the was on the unit. LPN-A stated ne was leaving the unit not communicated to the other is supervision purposes. LPN-A is off the unit, it was the e other staff on the different him. LPN-A stated it was all	2 830			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/		, ,	E CONSTRUCTION		E SURVEY PLETED
7.1.12 . 12 . 1.	0. 00.1.120.1011			A. BUILDING:			
		00149		B. WING			C <b>07/2019</b>
NAME OF	PROVIDER OR SUPPLIER	STRI	EET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DAYME	W NUIDOINO & DELLA	DU ITATION OFN: 141:	2 WES	T FOURTH	STREET		
BAY VIE	W NURSING & REHA	REI	D WING	9, MN 55066	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 14		2 830			
2 000	make decisions. LF that time whether the aware R1 had left the she was unaware of dated 12/12/18, that cognitive impairme aware of the guard not been allowed to been followed, and contacted.	PN-A stated she was unsume physician had been made he facility AMA. LPN- A state of the neuropsych examinate indicated R1 had severe nt. LPN-A stated had she itanship order, R1 would have been as a police would have been a police would have been as a police would have been a police would have been a police would have been a police would	ade tated ation e been ave ve	2 000			
	nursing assistant (Neperspective. NA-A facility on 4/10/19, Idays he was going stated during that ti and would tell him istated R1 left the face 4/10/19, wearing so was not aware of the impairment, per the indicated R1 had cathat day reporting hater returned to the department. NA-A Wanderguard on, voluilding independe a lot of time off the R1 talked about least home frequently. Nalert staff when he unit staff do not constations when R1 lew Wanderguards were every shift, and che shift. NA-A verified door alarm were to outside, if resident	NA)-A also provided histor stated prior to R1 leaving he had told staff for severato leave the facility. NA-A ime staff would redirect Rit was not a good idea. NA acility AMA on the morning everal layers of clothes. Nate level of R1's cognitive eneuropsych exam. NA-A alled the facility several times locations to staff and we facility by the police further stated R1 had a was able to walk around the ntly without escort, and spunit downstairs. NA-A state aving the facility and going A-A then stated, R1 would was leaving the unit hower municate to other nursing eaves the unit. NA-A state the checked for function every nitiacility protocol indicated go off, staff were to look was not seen, the charge and a head count done.	the al				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:	<u> </u>		
		00149	B. WING		06/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BILITATION CEN	ST FOURTH S G, MN 55060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 15	2 830			
	During an interview restorative nursing had been drinking a weeks. RNA-A indiwhether R1 had an stated he had spen R2 had been drinki almost daily he war further stated an ur responsibility it was off the unit; stated 'the receptionist "kir During an interview stated R1 frequentl home more on the day shift. NA-B stated and was able to maindependently. NA-was going downstated it was not constations when R1 werified it was facility went off, all staff werespond and check	on 6/4/19, at 8:34 a.m. assistant (RNA)-A stated R1 a lot during the last couple of cated an unawareness of ything to drink on 6/3/19, but at a lot of time in R2's room and ng. RNA-A stated R1 stated nted to go home. RNA-A nawareness of whose to supervise R1 once he was 'we all kind of do" and thought nd of knew what is going on".  on 6/4/19, at 8:42 a.m. NA-B by stated he wanted to go evening shift than during the ted R1 had a Wanderguard on ove about the facility B stated R1 told staff when he iris (off the unit) however, ommunicated to other nursing would leave the unit. NA-B also ty protocol if the Wanderguard ere responsible to immediately a outside. NA-B said if a und, a head count needed to				
	stated R1 had a Wimove around the fastated she had wor had been good in the afternoon, ar home. LPN-B state notified the administrand was not sure hupon-be indicated ar	on 6/4/19, at 8:58 a.m. LPN-B anderguard on but was able to acility independently. LPN-B ked on 6/3/19 and stated R1 he morning, had some alcohol ad had been stating he missed d around 3:30 p.m., she had stration R1 had been drinking ow he obtained the alcohol. ound 4:00 p.m. she had underguard alarm and had				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00149	B. WING			C <b>07/2019</b>
	PROVIDER OR SUPPLIER W NURSING & REHA	BILITATION CEN. 1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	found R1 outside the cigarette. LPN-B state out the wrong door under the influence R1 was more diffict she'd assisted R1 thand notified the administrated and notified the administrated and interview licensed social workstated an unawarent the facility were drifted facility were drifted and interview licensed social workstated and unawarent the facility had just alcohol consumptions stated there had not place from the last been working on demore comprehensive the use of alcohol splan.  During an interview LPN-C also stated implemented a new and there had been ensuring resident rifted to be clarification and the sure how R1 observed in the	ne main entrance smoking a lated she thought R1 had gone to smoke because he was . LPN-B indicated on that day, alt to redirect than usual, but to the enclosed smoking area, ministrator. LPN-B stated she left. LPN-B stated she left. In she left the building that of intoxicated.  If on 6/4/19, at 10:36 a.m. kers (LSW)-A and LSW-B less of how many residents in aking alcohol. LSW-A stated implemented a policy for in "today" (6/4/19). LSW-A at really been a good policy in owners and the facility had esigning and implementing a late plan. LSW-A further stated should be a resident's care  If on 6/4/19, at 11:51 a.m. the facility had just alcohol policy "today" 6/4/19, a some confusion about ghts to drink alcohol that leed. LPN-C stated an rinking alcohol however, was stained it.	2 830			
	Jeopardy for R1 on was removed on 6/ facility had provided and the plan could	ified of the Immediate 6/4/19, at 5:15 p.m. The IJ 5/19, at 4:33 p.m. when the d an acceptable removal plan, be verified as implemented ents with security devices were				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00149	B. WING		06/0	7/ <b>2019</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	BII ITATION CFN	ST FOURTH : G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	checked and accoupolicy and procedured developed and impalcohol use were deinformed of the revieducated as to how procedures for elopguidelines; and a mongoing compliance SUGGESTED MET. The administrator, designee could reviprocedures regardiconsumption, superesident's at risk for system, Facility starpolicies and procedure or designee could densure ongoing correlations.	inted for; A comprehensive are for elopement was demented; Guidelines for eveloped; All staff were are for implement, including perment and alcohol use are though of auditing to ensure a was developed and initiated.  THOD OF CORRECTION: director of nursing (DON) or iew, revise policies and ang implementation of alcohol rivision, identification of a elopement, and wander alert aff could be educated on these dures. The administrator, DON develop a monitoring system to	2 830			
21475	Subpart 1. General home must have an department or progrelated social service nursing home must collaborate with out who is in need of acceptance.	5 Subp. 1 Social Services: ents  I requirements. A nursing n organized social services ram to provide medically ces to each resident. A make referrals to or side resources for a resident dditional mental health, or financial services.	21475			7/7/19
	This MN Requirement by:	ent is not met as evidenced				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,	o. 00 <u>.</u>	.5	A. BUILDING		33 22.125
		00149	B WING		C <b>06/07/2019</b>
					1 06/07/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
BAY VIE	W NURSING & REHA	BILLIATION CEN	ST FOURTH G, MN 5506		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
21475	Continued From pa	ge 18	21475		
	failed to provide ne services related to (R1, R2, R6) review the facility.	and record review, the facility cessary behavioral health alcohol use for 3 of 3 residents yed for substance use within		R1 IS SAFE BACK AT FACILITY NO LONGER DRINKING ALCOH PHYSICIAN ORDER, GUARDIAN CONSENT, AND ALCOHOL GUIDELINES. R1'S CAREPLAN REVIEWED AND REVISED.	OL PER
	assessment dated independent with trambulation on and supervision with hy R1 had exhibited redays during the ass	mum Data Set (MDS) 3/29/19 indicated R1 was ansfers, was independent with off the units, and required giene. The MDS also indicated ejection of care behaviors 1-3 sessment period. ord, included diagnoses of rain injury (TBI), alcohol abuse,		R2 IS TRIALING AN ALCOHOL CONSUMPTION PROGRAM BAS PHYSICIAN ORDERS AND ALCO GUIDELINES. R2'S CARE PLAN REVIEWED AND REVISED.  R6 IS NO LONGER DRINKING ALCOHOL PER PHYSICIANS OF AND ALCOHOL GUIDELINES. RI CARE PLAN REVIEWED AND RI ALL OTHER RESIDENTS WITH	DHOL RDER 5'S
	R1's care plan did r to alcohol use.	not include information related		HISTORY OF ALCOHOLISM HAV FOCUSED CARE PLAN.	/E A
	On 6/3/19, a note dindicated earlier in	s reviewed included: locumented at 11:39 p.m. the shift, R1 had been under ohol and had eloped from the		ALL RESIDENTS WANTING TO CONSUME ALCOHOL HAVE A CAREPLAN AND/OR AN ORDER USAGE.	FOR
	facility. The note ind in the middle of a tr were called to conta behaviors. R1 had the emergency root aggressive behavior On 6/1/19, at 10:22 included: "Writer w facility unit] as [R1]	licated R1 ended up downtown affic intersection and police ain him due to erratic to be restrained and taken to m (ER) due to escalating ors.  I p.m. a progress note vas called down to 2W [a was drunk laying on the floor		IMPLEMENTATION OF THE RES ALCOHOL / SUBSTANCE GUIDE ON 6/4/2019 AND DISPERSED T RESIDENTS. POLICY UPDATED 6/20/2019 AND DISPERSED TO RESIDENTS AND STAFF AREAS REVIEW ON 6/21/2019.	ELINES O ALL ALL S FOR . STAFF
	going to call the pol upstairs and pulled	He got up after I told him I was lice. He refused to come away from staff. He went patio. Police were called to		PERTAINING TO THE RESIDENT ALCOHOL/SUBSTANCE GUIDEL STARTING 6/4/2019. REVIEW EDUCATION WILL BE COMPLETED	INES

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AND DLAN OF CORRECTION IDENTIFICATION NUMBER		IPLE CONSTRUCTION (X3) DATE SURVE COMPLETED				
			71. 501251110.		С	
		00149	B. WING			7/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	RILITATION CENT	ST FOURTH 3, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 19	21475			
21473	see if they could ge his room. He walke some point became and they took him in R1 incident note da "was reported to be this shift, [R1] spok [a staff name]. [R1] facility and was pict to the ER no injurie (message) left for freport done with Ac According to R2's fithe facility on 7/23/of abnormality of ga adjustment disorder	et him to comply with going to d upstairs with officer. He at a aggressive toward the police in police car." Ited on 6/3/19, at 9:23 p.m. a under the influence of alcohol en to by staff and supervisor, continued to drink then left ked up by the police and taken is reported to staff. Msg amily about incident police Itm (administrator) [name]."  acce sheet, R2 was admitted to 18, with an admitting diagnosis ait, history of seizures, r and alcohol dependence.	21470	JULY MONTHLY MEETINGS.  ALCOHOL ASSESSMENT CREA AND WILL BE COMPLETED ON RESIDENT BY JULY 5, 2019 ANI QUARTERLY.  AUDIT 24-72 HOUR REPORT FO ALCOHOL USE-INTOXICATED BEHAVIORS ONCE A WEEK FO WEEKS AND ONCE A MONTH F MONTHS.  OUTCOME WILL BE OBSERVED QAPI. DIRECTOR OF NURSING DESIGNEE WILL BE RESPONIB COMPLIANCE BY 7/5/2019.	EVERY D THEN DR R FOUR FOR 4 D AT OR	
	"Alteration in behave impulsivity and failed to include storage of alcohol. information about simpulsivity and impulsivity and failed to include storage of alcohol.	regard for the rights of others naviors, irritability, anger and onflict with authority, history of se, and impulsive, explosive cohol use within the facility. 19" Interventions included: intoxication, be alert for mood ges, use a kind and firm a voice, therapeutic touch, use se 30 minute checks, and one signs if R2 appears are plan did not include R2 drinking with other residents e directions related to safe R2's care plan did not include ervices to provide related to ehavioral health or social				

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	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			SURVEY PLETED	
74401 1544	or contraction	IDENTIFICATION NOMBER.	A. BUILDING:	:		
		00149	B. WING			C <b>07/2019</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
BAY VIE	W NURSING & REHA	RILITATION CEN.	EST FOURTH ING, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21475	R2's progress note p.m., indicated R2 staff had difficulty r indicated staff had the physician of his and disposed of op of vodka from R2's  According to R6's f admitted to facility diagnosis of repeat thrive, and with a d abuse.  R6's care plan incluit am adjusting ok to a history of alcohol trying to bring me a cannot have alcohol trying to bring me a cannot have alcohol trying to deal with iss facility, or how to perform to deal with iss facility, or how to perform to deal with iss facility, or how to perform to deal with iss facility, or how to perform to deal with iss facility, or how to perform to deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility, or how to perform the deal with iss facility and the deal with issue the deal with issue the deal with its facility.	e dated on 6/2/19, at 12:43 had become intoxicated and rousing the resident. The not taken vitals and later notified is condition. Staff also found ben, partially consumed bottle	s e e e e e e e e e e e e e e e e e e e			
	restorative nursing had been drinking					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00149		B. WING			C 0 <b>7/2019</b>
NAME OF	PROVIDER OR SUPPLIER		TREET AN		STATE, ZIP CODE	00/0	7//2019
		1		T FOURTH			
BAT VIE	W NURSING & REHA	BILITATION CEN R	RED WING	G, MN 55060	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21475	Continued From pa	ge 21		21475			
	daily he wanted to gunawareness of whe supervise R1 once "we all kind of do."  During an interview licensed practical n	RNA-A said R1 stated ago home. RNA-A stated alose responsibility it was he was off the unit by second 6/4/19, at 8:58 a.m. urse (LPN)-B stated sh	d an s to saying, . ne had				
	stated R1 had consafternoon, and she around 3:30 p.m. alsure how he had obsaid she'd found R2 smoking a cigarette thought he had gon smoke because he alcohol. LPN-B stat to redirect than usu the enclosed smoking administrator.	3/19 when R1 eloped. Is sumed some alcohol in had notified the adminitional R1's drinking but wo tained the alcohol. LPN 1 outside the main entrage around 4:00 p.m., and the out the wrong door to was under the influenced R1 had been more all, but she had assisted ing area and had notified	the istration was not N-B ance d ce of difficult d R1 to ed the				
	stated he kept alcoloupply it to R1. R2 shis own through loodrink whiskey. R2 shallohol in Gatorade had been drinking a would come to his restated over the weel and ended up hittin	on 6/4/19, at 10:15 a.m. hol in his room but did in stated R1 obtained alcotal friends and that R1 listated R1 would disguist bottles. R2 further state a lot the last few weeks room and drink socially exend, R1 was really drig a police officer over the ich R1 was put in hand the facility.	not chol on liked to se the ted R1 and R2 unk, he top				
	LPN-D said the fact assessment to be unabuse upon admiss	erview on 6/4/19 at 8:23 ility did not have a residused related to substan- sion to the facility. LPN- rit was explained to me	dent ce -D				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
,			A. BUILDING:			
		00149	B. WING		1	C <b>)7/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAY VIEV	V NURSING & REHA	RILITATION CEN	ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	stuff. Prior to that the up the pieces and to Just putting things to we had someone in bottle of booze. It's [Administrator] who past the ombudsmay we believe they are call the doctor first. I last administrator jufeel good. He pretty they wanted. It was a sudden it seemed alcohol." LPN-D fur state to one anothe get it this weekend. been aware of a prosubstance use in the weeks and had been that time, but it had buring interview on facility administrator recently developed alcohol use. The aput a new policy in rights because this consider the proble space. I wish I'd hay esterday. We have last month. I got the and I had it done are and sent it to the or can't just pull the all rooms. This is their like that. Some of the drinking at home are because they are "I'd and I had are and sent it to the or can't just pull the all rooms. This is their like that. Some of the drinking at home are because they are "I'd and I had it done are abecause they are "I'd and I had it done are and sent it to the or can't just pull the all rooms. This is their like that. Some of the drinking at home are because they are "I'd and I had it done are and sent it to the or can't just pull the all rooms. This is their like that. Some of the drinking at home are because they are "I'd and I had it done are "I'd and I'd and	ation allowed drinking and ney didn't. Now it's like we pick ry to put them back together. togetherThis past weekend in the entryway with a whole	21475	DETIGIENCI!)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00149	B. WING			C <b>07/2019</b>
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		****
BAV VIE	W NURSING & REHA	1412 WF	ST FOURTH			
DAT VIL	W NORSING & REHA	RED WIN	G, MN 55066	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 23	21475			
	is safe." The admir issue of safe storag stating, "It's been a wanted to store it in think we could just we have to have a put that we will store it. safe for the other redrinking becomes a to everyone at the sand all residents will discovered] will be a the safety of resident The administrator a was a standard asseriesident was suspensalcohol which involved.	n, but we need to assure that it histrator also addressed the pe of alcohol within the facility problem in the past. They the med cart but we didn't take people's alcohol like that, plan. Our policy is going to be Then we can make sure it is esidents and we can assess if an issue. The policy will go out same time. All staff will know that it [any alcohol prought to nurse's station for ints-others and themselves." Ilso stated she thought there essment completed if a cted to have been using yed notification of the sament of vital signs.				
	licensed social work stated they were un in the facility had just alcohol consumption stated there had no from the previous fathad been working of a more comprehensia resident's use of a the resident's care puring interview on registered nurse (R just implemented a there had been som resident rights to drobe clarified. RN-A s	on 6/4/19, at 10:36 a.m. Kers (LSW)-A and LSW-B aware of how many residents Irinking alcohol. LSW-A stated implemented a policy for n that day (6/4/19). LSW-A t been a good policy in place acility owners and the facility on designing and implementing sive plan. LSW-A also stated alcohol should be identified in plan.  6/4/19, at 11:51 a.m.  N)-A stated the facility had new alcohol policy 6/4/19, but ne confusion about ensuring ink alcohol which needed to tated an awareness of R1 wever, was not sure, how R1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						;
00149		00149	B. WING		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	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
21475	Continued From page 24		21475			
	obtained it.					
	SUGGESTED MET	HOD OF CORRECTION:				
	could work with the design an assessmabuse to be used u and at least yearly of Administrator and secould also define a refer persons with semost appropriate seferthermore, the ID storage plan for the alcohol within the face	social workers or designee plan for how to provide or substance abuse issues to the ervices for their condition.  OT team could develop a safe a safe and appropriate use of				

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