STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	03/11/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report allegations of resident to resident abuse timely to the State Agency (SA) for 4 of 4 residents (R1, R2, R3 and R4) reviewed for abuse. Findings include: R1's admission Minimum Data Set ((MDS) dated [DATE], indicated severe cognitive impairment, showed behaviors not directed towards others 1-3 days, and wandered 1-3 days during the 7 day assessment period, and required one person physical assistance with bed mobility, transfer, toileting, dressing, personal hygiene and eating. R1 was independent with ambulation in the corridor. R2's admission MDS dated [DATE], indicated severe cognitive impairment, did not have behavior issues directed towards others, wandered daily, and required two plus person physical assistance with bed mobility, transfer and toileting. R2 required one person physical assist with dressing, eating and personal hygiene. A facility reported incident to the state agency (SA) dated time of incident 3/4/20, at 9:55 a.m. however, this was not reported to the SA until 3/4/20, at 2:16 p.m or 4 hours and 21 minutes after the incident. In reviewing the incident statement the first punch by R2 to R1 was observed at 7:30 a.m. which would be six hours and forty-six minutes after the resident to resident abuse was observed before a report was filed with the SA. The facility reported to the SA on 3/4/20, at 2:16 p.m. This morning, (R1) was standing outside of the dining room when (R2) walked up to (R1), punched (R1) in the chest and took (R1's) hat off (R1's) head. NAR (nursing assistant, registered) had (R1) walk away with (NAR). (R1) was not injured. (R1) then was walking down the North hall and again (R2) walked up behind (R1) and punched (R1) in the back of the head. NAR told (R2) to leave (R1) alone and had (R1) come sit by (NAR) by the nursing cart. Resident was not injured. Resident and NAR were sitting together. (R2) came up from behind and punched (R1) and said, '[***] you [REDACTED]' and walked away. Resident was not injured. Resident (R1) was on 15 minute checks until (R1) left the building for an appointment and subsequently moved to a room off of the unit. Will continue with 15 minute checks for 24 hours during adjustment time period to new unit upon return from appointment. Document review of the description of the incident from the witness nursing assistant (NA-A) read, This morning around 7:30 a.m. (R1) was standing outside of the dining room when (R2) walked up to (R1), punched (R1) in the chest and took (R1's) hat off of (R1's) head. I had (R1) walk with me. 8:45 ish (R1) was walking down north hall and once again (R2) walked up behind (R1) and punched (R1) in the back of the head. I once again told (R2) to leave (R1) alone and had (R1) come sit by me by the nurses cart. 9:55 (R1) and I were sitting by each other so I could try and keep an eye on him. (R2) came up from behind and once again punched (R1) said [***] you [REDACTED] and walked away. When interviewed on 3/11/20, at 12:33 p.m. social service (SS)-A verified the director of nursing (DON) and administrator were not informed until around 11:00 a.m. on 3/4/20, and were directed to file a report with the SA which was not completed until 2:16 p.m. The SS-A verified the facility expectation was to file a report to the SA immediately, within two hours of any type of abuse occurring. R3's quarterly MDS dated [DATE], indicated severe cognitive impairment, had hallucinations and delusions, had behaviors directed towards others and not directed towards others 1-3 days during the 7 day assessment period, and required one person physical assistance with bed mobility, transferring, walking in the corridor, locomotion on the unit, dressing, eating, toileting and personal hygiene. R4's admission MDS dated [DATE], indicated R4 was cognitively intact, had delusions but no behavior issues, and was independent with bed mobility, transfer, and eating but required one staff assistance with walking in the corridor, locomotion off the unit, dressing, toileting and personal hygiene. Document review of the facility report to the SA read, Resident (R3) wandered into (R2's) room, via the bathroom door that adjoins the two rooms and was trying to find (R3's) way out of the room. (R3) is blind. (R4) was trying to assist (R3), but this agitated (R3) and (R3) became combative and punched (R4) in the back two times and also slammed the door shut on (R4's) right arm. (R4) immediately called 911 and the police came to take a statement. Initially, (R4) refused E[CONDITION] (emergency medical services) but as the police were talking to (R4) (R4) stated that (R4) would like E[CONDITION] to come, so that (R4) had documentation of the incident. E[CONDITION] did come to the facility but (R4) declined to go with them. Light bruising was noted to (R4) right hand. (R4) was moved to a different room at the far end of the hall for the night and (R3) was put on 15 minute checks to monitor whereabouts. The incident report identified it happened on 3/5/20, at 12:49 a.m. however, was not reported to the SA until 3/5/20, at 2:36 p.m. thirteen hours after the incident. Document review of the progress notes indicated the administrator and DON were informed of the abuse on 3/5/20, at 3:17 a.m. When interviewed on 3/11/20, at 1:43 p.m. the SS-B verified the facility expectation was to report incidents of abuse immediately, within two hours and stated, We had a breakdown in the communication system. The facility policy dated revision [DATE], titled Abuse Prevention Plan indicated all suspected maltreatment was to be reported to the State promptly. The administrator, director of nursing (DON), or nursing supervisor were to file a report and an internal investigation was to begin immediately.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to protect residents and thoroughly investigate allegations of resident to resident abuse for 4 of 4 residents (R1, R2, R3 and R4) reviewed for abuse. Findings include: R1's admission Minimum Data Set ((MDS) dated [DATE], indicated severe cognitive impairment, showed behaviors not directed towards others 1-3 days, and wandered 1-3 days during the 7 day assessment period, and required one person physical assistance with bed mobility, transfer, toileting, dressing, personal hygiene and eating. R1 was independent with ambulation in the corridor. R2's admission MDS dated [DATE], indicated severe cognitive impairment, did not have behavior issues directed towards others, wandered daily, and required two plus person physical assistance with bed mobility, transfer and toileting. R2 required one person physical assist with dressing, eating and personal hygiene. A facility report dated 3/4/20, This morning, (R1) was standing outside of the dining room when (R2) walked up to (R1), punched (R1) in the chest and took (R1's) hat off (R1's) head. NAR (nursing assistant registered) had (R1) walk away with (NAR). (R1) was not injured. (R1) then was walking down the North hall and again (R2) walked up behind (R1) and punched (R1) in the back of the head. NAR told (R2) to leave (R1) alone and had (R1) come sit by (NAR) by the nursing cart. Resident was not injured. Resident and NAR were sitting together. (R2) came up from behind and punched (R1) and said '[***] you [REDACTED]' and walked away. Resident was not injured. Resident (R1) was on 15 minute checks until (R1) left the building for an appointment and subsequently moved to a room off of the unit. Will continue with 15 minute checks for 24 hours during adjustment time period to new unit upon return from appointment. Document review of the description of the incident from the witness nursing assistant (NA)-A included, This morning around 7:30 a.m. (R1) was standing outside of the dining room when (R2) walked up to (R1), punched (R1) in the chest and took (R1's) hat off of (R1's) head. I had (R1) walk with me. 8:45 ish (sic) (R1) was walking down north hall and once again (R2) walked up behind (R1) and punched (R1) in the back of the head. I once again told (R2) to leave (R1) alone and had (R1) come sit by me by the nurses cart. 9:55 (R1) and I were sitting by

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

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) each other so I could try and keep an eye on him. (R2) came up from behind and once again punched (R1) said [***] you [REDACTED] and walked away. R1's care plan (CP) was not updated for the resident to resident abuse on 3/4/20 until [DATE], and read, At risk for vulnerability r/t (related to) dx (diagnoses) [MEDICAL CONDITION] and impaired mobility. (R1) has been hit by another resident, (R2) keep (R1) away from (R2) as much as possible. R2's CP was not updated for the resident to resident abuse on 3/4/20 until [DATE], and read, No known history of violet crime or physical aggression prior to admission. At risk for vulnerability r/t dx of Wernicke's [MEDICAL CONDITION] (presence neurological symptoms). Observe for new violent or aggressive behavior. Initiate individualized steps to minimize risk to resident, peers, staff, visitors and those outside the facility. R2's CP for behavior was updated [DATE], and read (R2) has hit (R1) Redirect (R2) away from (R1) as often as possible. R1 was observed on 3/11/20, at 11:34 a.m. sitting in the dining room having lunch and talking about Africa. When asked, R1 did not recall the incident on 3/4/20, being hit by (R2). R2 was observed on 3/11/20, at 11:33 a.m. sitting by the nurses station and one other resident was seated 10 feet from R2. When interviewed on 3/11/20, at 11:36 a.m. NA-B indicated being involved with the 15 minute checks for R1, and verified R1 does not remember the incident, nor was R1 interviewable. NA-B did not know why R2 was not placed on 15 minute checks since R2 was the alleged aggressor and struck out at R1. When interviewed on 3/11/20, at 11:40 a.m. NA-C verified there were no 15 minute checks initiated for R2 as the aggressor against R1 and stated, I don't know why we didn't do 15 minute checks on (R2). We should start that right now. When interviewed on 3/11/20, at 12:01 p.m. licensed practical nurse (LPN-A) stated, I did the 15 minute checks on (R1) because (R1) is the one who was hit by (R2), maybe I should have done the checks on (R2) since (R2) is the one who hit (R1). Then they moved (R1) off the unit for the weekend and now (R1) is back again so maybe we should be watching (R2) every 15 minutes but we have not started that yet. LPN-A explained R1 was extra vulnerable as he would wander into others rooms and had bowel movements in inappropriate areas. LPN-A did not know of any comprehensive assessment on R1's behaviors or ways to decrease the likelihood of other residents targeting him related to his behavior of wandering or having bowel movements in inappropriate places. When interviewed on 3/11/20, at 12:23 p.m. house keeper (HSK)-A stated, R2 has struck other residents, had punched her and has followed her. HSK-A had not reported this. HSK-A stated he becomes violent so quickly and did not know of any interventions placed to prevent R2 from striking staff or residents. When interviewed on 3/11/20, at 2:01 p.m. the director of nursing (DON) did not know why 15 minute checks were not implemented on R2 as the aggressor. The DON verified the investigation lacked individual statements from other residents and more staff, that may lead to insight on how to prevent recurrence. A comprehensive assessment of R1 and R2 had not been completed in order to provide interventions that may reduce the chance of recurrence. R3's quarterly MDS dated [DATE], indicated severe cognitive impairment, had hallucinations and delusions, had behaviors directed towards others and not directed towards others 1-3 days during the 7 day assessment period, and required one person physical assistance with bed mobility, transferring, walking in the corridor, locomotion on the unit, dressing, eating, toileting and personal hygiene. R4's admission MDS dated [DATE], indicated R4 was cognitively intact, had delusions but no behavior issues, and was independent with bed mobility, transfer, and eating but required one staff assistance with walking in the corridor, locomotion off the unit, dressing, toileting and personal hygiene. A facility incident report included, Resident (R3) wandered into (R4's) room, via the bathroom door that adjoins the two rooms and was trying to find (R3) way out of the room. (R3) is blind. (R4) was trying to assist (R3), but this agitated (R3) and (R3) became combative and punched (R4) in the back two times and also slammed the door shut on (R4's) right arm. (R4) immediately called 911 and the police came to take a statement. Initially, (R4) refused E[CONDITION] (emergency medical services) but as the police were talking to (R4) (R4) stated that (R4) would like E[CONDITION] to come, so that (R4) had documentation of the incident. E[CONDITION] did come to the facility, but (R4) declined to go with them. Light bruising was noted to (R4) right hand. (R4) was moved to a different room at the far end of the hall for the night and (R3) was put on 15 minute checks to monitor whereabouts. R3's CP was not updated following the 3/4/20, resident to resident abuse but on 1/23/20, an intervention under the behavior plan read, Keep away from resident 6697 as much as possible. Resident has made verbal threats toward (R3). R3 was observed on 3/11/20, at 11:30 a.m. sitting in a chair by the nurses station and one other resident was seated 10 feet away. R4's CP was not updated following the resident to resident abuse on 3/4/20 but was dated 2/29/20 , and read, Safety vulnerability abuse prevention; (R4) has no history of violent crime or violence towards others or received prior to admission. (R4's) risk for abuse will be minimized via POC (plan of care) and facility abuse prevention plan through next review date to maintain safety and feelings of well-being through next review date. When interviewed on 3/11/20, at 11:36 a.m,. NA-B verified the facility was completing 15 minute checks on R3 since hitting R4. However, was unaware of any other interventions put in place to prevent altercations between R3 and R4. When interviewed on 3/11/20, at 11:40 a.m. NA-C verified 15 minute checks were being documented on a paper form. NA-C stated, (R3) should have (R3) own bathroom so that (R3) doesn't go through the shared bathroom into the other resident's space. (R3) may have been overstimulated because the family had all been in for (R3) birthday and everyone should have known to watch (R3) for aggressive behavior. (R3) has stabbed me with a fork when overstimulated and that is why everyone is on plastic utensils up on this unit. Sometimes (R3) tries to stick the fork in the electrical outlets and we should watch for that also. Furthermore NA-C stated, Staffing is pretty decent, but I have told management we need 3 aides on the day and evening shift for these behaviors and probably more staff on the night shift if we need one on one to watch the aggressive known hitters like (R1 and R4). NA-C did not know why these specific issues with overstimulation and stabbing with the fork were not addressed on the CP but stated, They should be so everyone knows to watch for it. When interviewed on 3/11/20, at 11:51 a.m. NA-D stated, more staff would be helpful because they seem to need more one on one to watch the residents who abuse others especially (R1 and R4). When interviewed on 3/11/20, at 12:18 p.m. NA-E stated, Someone always needs to be watching (R1 and R4) because we never know what will provoke them, the staffing needs more if we are going to prevent the injuries especially of these residents who hit. Some days the behaviors are worse. I have told administration we need more staff, people watching the floor better. When interviewed on 3/11/20, at 12:23 p.m. housekeeper (H-A) stated, Last week (R3) punched me two times in the face for no reason, and followed me. I think they need more staff, they become aggressive so fast and it is difficult to know when they are going to strike out. When interviewed on 3/11/20, at 12:45 p.m. LPN-C who was the nurse manager for the locked unit, did not know why (R3) was not put on 15 minute checks to protect the other residents in the unit since (R3) had displayed aggressive behaviors to the staff and other residents prior to this situation, but indicated would initiate 15 minute checks on (R3) to prevent others from being abused immediately. Furthermore, LPN-C did not know that the housekeeper was hit by (R3) but would report to management immediately. LPN-C verified other staff members have been harmed by (R3) and they needed a better plan to protect the staff and other residents. LPN-C verified statements were not obtained from the night shift as to the details of the incident between R3 and R4 and verified the facility investigation was not followed. LPN-C indicated R2 had struck out and yelled at R1 in the past and the facility should have addressed steps in the CP to prevent R2 from abusing R1 so many times. When interviewed on 3/11/20, at 2:01 p.m. the director of nursing (DON) did not know why 15 minute checks were not implemented on (R3) as the aggressor. The DON verified individual statements were not obtained from the night shift staff who were present and the staff should have investigated more thoroughly to prevent a re-occurrence. The DON verified the facility expectation would be to follow the Abuse policy and procedure. The DON verified the CP's were not comprehensively, and individually updated for R1, R2, R3, and R4 with clear steps to prevent a re-occurrence of the abuse. The DON verified the staff were not re-trained following the abuse accusations for the four residents and the facility failed to audit the residents to prevent further incidents according to the facility policy. When interviewed on 3/11/20, at 2:30 p.m. R4 stated, They do not have enough staff to deal with these behavior injuries, (R3) is hurting the staff here, last week I heard (R3) broke a staff arm. I am still having pain and I am afraid the staff cannot protect me or themselves. I am so afraid (R3) is going to attack me again especially when you know he is punching the staff. I was sleeping when(R3) first came into my room and I rang the bell and no one came for 15 minutes so I called 911 Then I went out to try to find the staff, I called help, help help. They both must have gone to break at the same time. (R3) prowls around at night. (R3) sleeps all day and prowls around at night. Then the police officer showed up for the assault. Document review of the facility policy dated revision [DATE], titled Abuse Prevention Plan indicated the designated staff on duty would begin investigating the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document such findings. Residents, the alleged perpetrator, and other staff will be protected from harm during an investigation. The accused abuser must be separated from all dependent adult. The unit manager/night supervisor does an investigation of the event and implements immediate changes to keep the resident safe; with follow up/implementation reviewed to make sure that they are appropriate for resident and condition of resident.