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 _____	06/04/2020

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide monitoring, assessments and document all events following a [MEDICAL CONDITION] to identify changes in condition according to care plan for 1 of 1 residents (R1) reviewed for accidents. R1 has a history of [MEDICAL CONDITION] related to [MEDICAL CONDITION]. Findings include: R1's Admission Record, included [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R1's cognitive skills for daily decision making was severely impaired, required supervision for activities of daily living that involved mobility, and required extensive assistance from one staff for toilet transfers, eating, dressing, and bed mobility. R1's progress note dated 5/29/2020, at 9:33 a.m. included, 8:30 a.m., CNA (certified nursing assistant) called writer into resident's room as resident was having a [MEDICAL CONDITION]. Writer entered res (resident) room and found resident lying in bed with his head turned to the right noted tremors in upper extremities and LE (lower extremities) with some movement, pupils rolled back and resident unresponsive. [MEDICATION NAME] (is used to treat anxiety, alcohol withdrawal, and [MEDICAL CONDITION]. It is also used to relieve muscle spasms and to provide sedation before medical procedures.) sublingular (sic) 1 ml administered at 0835 (8:35 a.m.) and tremors stopped shortly after resident started to responded to staff. B/P (blood pressure) 151/90-83-18 T 97.5 (Temperature). Resident responding with eyes, skin is cool to the touch. Call placed to POA/HC (power of attorney/health care) and informed her of [MEDICAL CONDITION] activity, call placed to (name of provider) and informed her of [MEDICAL CONDITION] activity. Instructed this nurse to monitor resident for any further [MEDICAL CONDITION] activity or a change in status. R1's neurological care plan dated 5/5/19, included R1 had a history of [REDACTED]. The associated goal included, Stop any current [MEDICAL CONDITION] activity as soon as possible, minimize damage, and prevent from occurring in the future. Interventions directed staff to: -POST [MEDICAL CONDITION] TREATMENT: Turn on side with head back, hyper-extended to prevent aspiration, Keep airway open, After [MEDICAL CONDITION] take vital signs and neuro check, Monitor for [MEDICAL CONDITION], headache, altered LOC, paralysis, weakness, pupillary changes. -[MEDICAL CONDITION] DOCUMENTATION: location of [MEDICAL CONDITION] activity, type of [MEDICAL CONDITION] activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after [MEDICAL CONDITION] activity. [MEDICAL CONDITION] meds will be administered as ordered, monitor for effect and side effects -[MEDICAL CONDITION] PRECAUTIONS: Do not leave resident alone during a [MEDICAL CONDITION], Protect from injury, If resident is out of bed, help to the floor to prevent injury, Remove or loosen tight clothing, Don't attempt to restrain resident during a [MEDICAL CONDITION] as this could make the convulsions more severe, Protect from onlookers, draw curtain etc. -monitor neurological status after any activity for residual impairment -Notify physician, provide privacy and dignity during [MEDICAL CONDITION] activity -administer [MEDICAL CONDITION] medications as ordered, monitor for effect and side effects. R1's record did not include any further follow-up after the above incident according to the interventions listed on R1's care plan until 1:22 p.m. R1's physician orders [REDACTED]. Give under the tongue for [MEDICAL CONDITION] longer than 3 minutes or for [MEDICAL CONDITION] cluster. Okay to repeat after 10 minutes if [MEDICAL CONDITION] continues. Inform MD for persisting [MEDICAL CONDITION] (start date 1/28/2020). During an interview on 6/4/2020, at 11:40 a.m. licensed practical nurse (LPN)-A, indicated she was the nurse that responded to R1's [MEDICAL CONDITION] the morning of 5/29/2020. LPN-A indicated the nursing assistant (NA) noticed R1 was having a [MEDICAL CONDITION], and called for LPN-A. LPN-A said when she entered the room R1's head, and upper and lower extremities were tremoring. LPN-A stated she gave him the dose of [MEDICATION NAME], took his vital signs, and rubbed his arms then he started responding. LPN-A indicated an unawareness of how long R1's [MEDICAL CONDITION] had started prior to staff becoming aware, the [MEDICATION NAME] was given immediately, the [MEDICAL CONDITION] stopped about 5 minutes after the medication, and the witnessed episode probably lasted around 7-10 minutes. LPN-A indicated that after the [MEDICAL CONDITION] staff checked on R1 at least every hour if not more frequently, took R1's vital signs and completed neurological checks every couple of hours however, did not document every time she was in his room. LPN-A indicated R1 slept on and off all day and didn't have any more [MEDICAL CONDITION]. During a subsequent interview at 2:32 p.m., LPN-A stated she when a resident has a [MEDICAL CONDITION] the LPN-A documented a note to include vitals, alertness, orientation status, skin color, and a general assessment. LPN-A stated she had not been orientated to anything specific for [MEDICAL CONDITION] documentation. LPN-A stated she was not aware R1's care plan included what to document when R1 had a [MEDICAL CONDITION]. Progress note dated 5/29/2020, at 1:22 p.m. indicated R1 had not had any further [MEDICAL CONDITION] activity since this morning and had been resting on and off. Progress note at 9:34 p.m. indicated R1 did not have any [MEDICAL CONDITION] activity, ate his supper, and took medications without any problems. Vital signs that were obtained at this time were respiratory rate, oxygen saturations, and temperature, which were recorded in the Treatment Administration Record for the day and evening shift, although they did not identify the time of day values were obtained. The last documented vital signs assessment or neurological monitoring for R1 was from 9:33 a.m. 5/29/20 and again at 10:15 p.m. During an interview on 6/5/2020, at 3:33 p.m. registered nurse (RN)-A indicated he worked the overnight shift that started at 10:00 p.m. RN-A indicated he was made aware R1 had a [MEDICAL CONDITION] earlier that morning during shift report. RN-A stated an aide walked by R1's room at around 10:15 p.m. and found R1 sitting on the floor, did not have any injuries, and was alert and orientated. RN-A was not sure if R1 had hit his head so neurological assessments were implemented. RN-A stated at 11:30 a.m. R1 had another [MEDICAL CONDITION] that lasted 7-10 minutes, and was administered the [MEDICATION NAME] two to three minutes after the [MEDICAL CONDITION] started. RN-A indicated the [MEDICAL CONDITION] resolved two or three minutes after the [MEDICATION NAME] was administered. RN-A indicated he took R1's vital signs, noted the change to R1's condition, and called for an ambulance. RN-A then indicated when the ambulance arrived, they thought R1 was fine and did not need to be taken to the emergency room until R1 had another [MEDICAL CONDITION] in front of them. RN-A stated R1 was given another dose of [MEDICATION NAME] was taken to the emergency room at 12:40 a.m. R1's nursing progress notes do not reflect real-time entries nor are they recorded as a late entry. Even though the record indicated R1 was sent to the emergency room at 12:40 a.m., the documentation indicated R1 was administered medication at 1:09 a.m. and a progress note at 2:40 a.m. indicated R1 was found on the floor by an NA laying on his back by his bed with no visible injuries, may have lost his balance, was transferred back to bed. The note indicated R1's neurological assessment was per his baseline, vital signs were obtained blood pressure 142/96, pulse 100, respirations 20, and temperature 96.2, and R1 was placed on frequent checks. Progress note dated 5/30/2020, at 9:35 a.m. indicated family had communicated to the facility R1 was having surgery for [REDACTED]. During an interview on 6/4/2020, at 2:24 p.m. hospital neurology registered nurse (RN)-B stated she was the charge nurse on the floor where R1 was being cared for. RN-B stated R1 had a shunt in his brain that was not working correctly, brain hemorrhage, skull fractures, and a large hematoma. RN-B indicated the malfunctioning of the shunt could cause changes to level of

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) consciousness and potentially cause [MEDICAL CONDITION]. RN-B stated the standard for monitoring after a [MEDICAL CONDITION] episode depends on the patient, however at minimum vital signs and neurological status should be obtained and assessed 30 minutes following a [MEDICAL CONDITION] and then every 4 hours. RN-B indicated it was important to routinely assess someone after they had a long [MEDICAL CONDITION] in order to maintain safety and for the potential to stop reoccurrence. During interview on 6/4/2020, at 3:55 p.m. the assistant director of nursing (ADON) stated she would have expected the staff member to document what was care planned for [MEDICAL CONDITION] documentation. The ADON stated this (what staff should include in [MEDICAL CONDITION] documentation) should have also been in the TAR (treatment administration record) so staff would know what to document. At 5:26 p.m. ADON reviewed R1's record and confirmed the record lacked evidence of monitoring per physician orders [REDACTED]. Facility protocol Nursing Management of [MEDICAL CONDITION] dated 2020, included the following: Note time [MEDICAL CONDITION] started. Note any sounds or movements that precede the [MEDICAL CONDITION]. Observe entire body, type and progression of body movements (tonic or clonic) and specific area(s) of the body involved. Monitor vital signs as indicated. When [MEDICAL CONDITION] subsides, observe resident at frequent intervals until condition is stable. Assess change in mental and/or physical function after [MEDICAL CONDITION] subsides. Facility policy Charting By System dated 1/2016, indicated the purpose of the policy was to provide staff guidelines for charting by symptom. The charting guidelines for [MEDICAL CONDITION] included: duration, type of [MEDICAL CONDITION], medication/lab levels, number of [MEDICAL CONDITION], vital signs, and describe aura(a warning sensation experienced before an attack of [MEDICAL CONDITION] or migraine) if present.