STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. Building B. Wing	11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43087 Based on interview and document review, the facility failed to ensure a comprehensive skin assessment was completed to identify interventions to avoid the development of pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers who developed pressure ulcers. This resulted in actual harm to R1 when she developed two Stage 2 pressure ulcers. Findings include: Pressure Ulcer Staging according to National Pressure Ulcer Advisory Panel (NUPAP): Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition. The MDS indicated R1's diagnoses included progressive neurological loss resulting in inability to move any extremity, and respiratory failure requiring continuous mechanical ventilation and a tracheostomy (opening in neck for attachment of breathing tube). The MDS also indicated R1 was totally dependent on staff for all care, requiring assistance of two or more for bed mobility, toileting, and personal hygiene. In addition, the MDS indicated R1 had a feeding tube, an indwelling urinary catheter, and was incontinent of bowel and bladder. The MDS indicated R1 had no pressure ulcers or other skin issues. R1's Comprehessive Admission assessment dated [DATE], indicated R1's skin was intact with the exception of a surgical incision on the cervical spine that was clean and non-infected. R1's Care Area Assessment (CAA) worksheet dated 10/11/21, lacked assessment of R1's pressure ulcer risk and lacked an assessment of R1's skin integrity. The CAA further indicated this would be addressed in R1's care plan. R1's care plan dated 10/4/21, indicated R1 was at risk for pressure ulcers. Interventions included monitor her skin during daily care, weekly skin inspection by the nurse, turning every two to three hours, use of a pressure redistribution mattress on bed and in wheelchair, and pericare after each incontinence episode. The care plan also indicated R1 should have her incontinence brief checked and changed every two to three hours. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Nursing Assistant Care Card (nursing assistant care guide) undated, indicated R1 was to have her incontinence brief checked and changed every three hours, and she was to be repositioned every three hours. R1's weekly skin checks documented on the Shower Sheet were as follows: - 10/20/21, no reddened areas; dry flaky skin on hands and feet - 10/27/21, no skin issues were documented - 11/3/21, dry flaky skin on hand and feet documented; no other skin issues were documented No other weekly skin check sheets were provided by the facility. R1's Treatment Administration Record (TAR) dated October 2021, indicated R1 did not have a weekly skin check on 10/6/21, or 10/13/21, but had skin checks on 10/20/21, and 10/27/21; outcomes of any skin checks were not documented in R1's electronic medical record (EMR). R1's TAR dated November 2021, indicated R1 had a weekly skin check on 11/3/21, but outcomes of the skin checks were not documented in the EMR. R1's Reposition Every 2 hours Log provided 11/17/21, indicated the following documentation: September 2021 - 9/28/21 documentation at 12:15 p.m. and 2:00 pm. - 9/29/21 documentation every 2 to 2.5 hours starting at 12:00 a.m. with position alternating between door, window, and back - 9/30/21 documentation only at 12:00 a.m., 2:00 a.m., and 4:40 a.m.; at 2:00 a.m. family requested she not be repositioned because she was asleep; incontinence product was wet when repositioned. October 2021 - From 10/1/21 through 10/27/21, documentation was sporadic and not every two hours; it did not always indicate position changes or status of incontinence brief. There was no documentation for 10/28/21, 10/29/21, 10/30/21, and 10/31/21. R1's Reposition every 3 hours Log provided 11/16/21, indicated the following documentation: 11/1/21 - 9:00 p.m. position was on her back and wet; no indication of position change 11/2/21 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 12:00 a.m. had tucked pillows and wet; no indication of position or change of position - 2:00 a.m. refused position change; no indication of position or status of incontinence brief - 4:00 a.m. refused position change; no indication of position or status of incontinence brief 11/3/21 - 12:00 a.m. refused position change; no indication of position or status of incontinence brief - 2:00 a.m. refused position change; no indication of position or status of incontinence brief - 4:00 a.m. position was on her back and wet; no indication of position change 11/4/21 - 12:30 a.m. position was on her back and wet with feces present; no indication of position change - 6:00 a.m. refused position change; no indication of position or status of incontinence brief - 8 a.m. documentation was left blank - 10 a.m. position was toward door and wet; no indication of position change - 2:30 p.m. position in new chair with therapy and was dry - 5:00 p.m. returned to bed and was dry - 9:00 p.m. position was on her back and wet with feces present; no indication of position change - 3:30 a.m. position was on her back and wet; no indication of position change - 7:00 a.m. position was on her back and wet; no indication of position change - 9:00 a.m. refused position change and was dry; no indication of position 11/5/21 - 6:30 p.m. position on back and was wet with feces present; no indication if position changed - 9:00 p.m. refused position change; no indication of position or status of incontinence brief 11/6/21 - 12:00 a.m. refused position change; no indication of position or status of incontinence brief - 2:00 a.m. refused position change; no indication of position or status of incontinence brief (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 4:45 a.m. position was on back and wet with feces present; no indication of change - 7:00 a.m. refused position change and was dry; no indication of position - 11:30 a.m. position was on back and incontinence brief was wet; no indication if repositioned - 3:00 p.m. position was on back and refused to reposition; status of incontinence brief not documented - 6:00 p.m. refused position change; no indication of position or status of incontinence brief - 9:30 p.m. position was on back and incontinence brief was wet with feces present 11/7/21 - 12:00 a.m. refused repositioning; no indication of position or status of incontinence brief - 2:00 a.m. refused repositioning; no indication of position or status of incontinence brief - 4:00 a.m. only documentation was finally sleeping; no indication of position or status of incontinence brief No other times were documented. There was no documentation of position or position changes in the EMR. R1's medical record lacked documentation of any assessment to determine how much time R1 could stay in any one position before her skin tissue was negatively affected. On 11/7/21, at 12:41 p.m. a progress note indicated R1 left the facility via ambulance because she was lethargic and not responsive. The local hospital's emergency department (ED) provider note dated 11/7/21, indicated R1 arrived at the ED around on 11/7/21, at approximately 10:30 a.m. and her incontinence brief was soaked with urine. The hospital's admission nursing note dated 11/7/21, indicated R1 arrived at the local ED in a heavily soiled brief and upon catheterization, purulent urine was noted in the [urine] collection system. Upon arrival to the receiving hospital's intensive care unit (ICU), the note indicated R1 had wounds on the insides of her thighs, on her labia, on her buttocks, on her coccyx, and surrounding her perineum. The receiving hospital's Wound Ostomy Care Wound Nurse note dated 11/8/21, indicated R1 had: 1. Moderate severity incontinence associated dermatitis from groin to perineum 2. Irregularly shaped friction injury (Stage 2 Pressure Ulcer) on left buttock - no measurement provided (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3. Irregularly shaped friction injury (Stage 2 Pressure Ulcer) on sacrum - no measurement provided During an interview on 11/10/21, at 9:26 a.m. the hospital acute care registered nurse (RN)-A stated upon admission to the acute care facility, R1 was noted to have two pressure ulcers, one on her buttocks and one on her sacrum. RN-A stated R1 had cherry red dermatitis along her incontinence brief and on both inner thighs, stating, I've never seen skin that bad before. During an interview on 11/12/21, at 10:15 a.m. NA-A stated she worked with R1 on the evening and night shifts prior to her being sent to the hospital. NA-A stated R1 was to have her incontinence brief checked and changed every two hours and she was to be repositioned every two hours, but she was refusing because she was in a lot of pain. NA-A stated R1 turned her call light on constantly because of her pain. NA-A stated R1 did not want to be turned because she was in so much pain. NA-A stated R1 was not repositioned that night. During an interview on 11/12/21, at 2:53 p.m. the ED medical doctor (MD)-A stated when R1 arrived at the ED her incontinence brief was soaked and she had redness in her inner thighs; he did not check for pressure ulcers because she was significantly ill with sepsis from respiratory and urinary tract infections. MD-A stated wet incontinence briefs increased the chance of a resident developing urinary tract infections. During an interview on 11/15/21, at 12:17 p.m. RN-B stated she was aware R1 had redness from incontinence and directed staff to use a barrier cream. RN-B stated they had not assessed R1 to determine how long she could remain in a position before her tissue integrity was affected. During an interview on 11/15/21, at 2:45 p.m. RN-D stated it took two NAs and one RN to turn R1 because the RN watched the head and her tracheostomy site, while the NAs turned R1. RN-D could not remember turning R1 during the night. During an interview on 11/15/21, at 3:10 p.m. the director of nursing (DON) stated the facility completed position logs on residents if it made the family feel better, if residents were refusing turning, or if the resident had a bad wound; otherwise, there was no documentation of repositioning. The DON stated the expectation was for NAs to document on the log, and then the nurse document in the EMR. If a resident refused, the DON stated she expected staff to document any behaviors and why refused on the log, and then nurses would document in the progress note. The DON verified there was no documentation of refusals in R1's progress notes. During an interview on 11/16/21, at 12:58 p.m. the wound ostomy care nurse (WOCN)-A at the receiving hospital stated R1 entered the acute care facility with a Stage 2 friction shear/pressure ulcer on her upper left buttock, and one Stage 2 friction shear/pressure ulcer on her sacrum; she also had incontinence associated dermatitis correlated to where her skin was in contact with an incontinence brief. WOCN-A stated the incontinence associated dermatitis was moderate in severity. WOCN-A stated it would take days of exposure to urine for the incontinence associated dermatitis to develop. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/16/21, at 1:48 p.m. the DON stated the facility did not complete a formal skin assessment tool or any type of tissue tolerance assessment except on admission to the facility. The DON verified R1 did not have any pressure ulcers on admission to the facility, and no pressure ulcers were documented during her stay at the facility. The DON stated a skin check was documented on the weekly shower tool (paper) and then the tool would be uploaded into the EMR. The DON verified the shower tool had not been uploaded in the EMR; they had a paper record for 11/3/21, and other paper records where supplied after survey exit. The DON believed missing paperwork, including medication administration record, were sent to the ED when R1 was transported there for emergency care. The DON stated the facility's routine was to turn residents every two to three hours; they started with two hours and if they thought they were okay, they would extend to every three hours. The DON stated because R1 was doing okay, they thought she could proceed to be repositioned every three hours. The facility Resident Examination and Assessment policy dated February 2014, directed a resident's skin would be assessed for intactness, moisture, color, texture, and presence of bruises, pressure sores, redness, edema, or rashes. The policy also directed results would be document in the resident's medical record. The policy lacked indication of the frequency of skin exams.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43087 Based on observation, interview and document review, the facility failed to comprehensivily assess and implement interventions for incontinent care for 1 of 3 residents (R1) identified as having urinary incontinence. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition and diagnoses of progressive neurological loss resulting in inability to move any extremity and respiratory failure requiring continuous mechanical ventilation and a tracheostomy (hole in neck for attachment of breathing tube). The MDS also indicated R1 was totally dependent on staff for all care, requiring assistance of two or more for bed mobility, toileting, and personal hygiene. The MDS indicated R1 had a feeding tube, an indwelling urinary catheter, and was incontinent of bowel and bladder. R1's Care Area Assessment (CAA) worksheet dated 10/11/21, indicated R1 should be check for urinary incontinence every two to three hours. R1's Care Plan dated 10/4/21, indicated R1 should have her incontinence brief checked and changed every two to three hours. R1's Reposition every 2 hours Log provided 11/17/21, indicated the following documentation: September 2021 - 9/30/21 documentation only at 12:00 a.m., 2:00 a.m., and 4:40 a.m.; at 2:00 a.m. incontinence product was wet when repositioned. October 2021 - From 10/1/21 through 10/27/21, documentation was sporadic and not every two hours; it lacked consistent indication indicate if R1 had been incontinent. There was no documentation for 10/28/21, 10/29/21, 10/30/21, and 10/31/21. R1's Reposition every 3 hours Log provided 11/16/21, indicated the following documentation: 11/1/21 - 9:00 p.m. R1was incontinet of urine 11/2/21 - 12:00 a.m. R1 was incontinet of urine (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2:00 a.m. no indication of incontinence status - 4:00 a.m. no indication of incontinence status 11/3/21 - 12:00 a.m. no indication of incontinence status - 2:00 a.m. no indication of incontinence status - 4:00 a.m. R1 was incontinet of urine 11/4/21 - 12:30 a.m. R1 was incontinent of stool - 6:00 a.m. no indication of incontinence status - 8 a.m. documentation was left blank - 10 a.m. R1 was incontinet of urine - 2:30 p.m. R1 was dry - 5:00 p.m. R1 was dry - 9:00 p.m. R1 was incontinent of bowel and bladder - 3:30 a.m. R1 was incontinent of urine - 7:00 a.m. position was on her back and wet; no indication of position change - 9:00 a.m. R1 was incontinent of urine 11/5/21 - 6:30 p.m. R1 was incontinent of bowel and bladder - 9:00 p.m. no indication of incontinence status 11/6/21 - 12:00 a.m. no indication of incontinence status - 2:00 a.m. no indication of incontinence status - 4:45 a.m. R1 was incontinent of bowel and bladder (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7:00 a.m. R1 was dry - 11:30 a.m. R1 was incontinent of urine - 3:00 p.m. no indication of incontinence status - 6:00 p.m. no indication of incontinence status - 9:30 p.m. R1 was incontinent of bowel and bladder 11/7/21 - 12:00 a.m. no indication of incontinence status - 2:00 a.m. no indication of incontinence status - 4:00 a.m. no indication of incontinence status No other times were documented. On 11/7/21, at 12:41 p.m. a progress note indicated R1 left the faciity on [DATE], via ambulance because she was lethargic and not responsive. The local hospital's emergency department (ED) provider note dated 11/7/21, indicated R1 arrived at the ED around 10:30 a.m. and her incontinence brief was soaked with urine. The hospital's admission nursing note dated 11/7/21, indicated R1 arrived at the local ED in a heavily soiled brief and upon catheterization, purulent urine was noted in the [urine] collection system. Upon arrival to the intensive care unit (ICU), the note indicated R1 had wounds on the insides of her thighs, on her labia, on her buttocks, on her coccyx, and surrounding her perineum. The hospital's Wound Ostomy Care Wound Nurse note dated 11/8/21, indicated R1 had moderate severity incontinence associated dermatitis from groin to perineum. During an interview on 11/10/21, at 9:26 a.m. the hospital acute care registered nurse (RN)-A stated upon admission to the acute care facility, R1 had cherry red dermatitis along her incontinence brief and on both inner thighs, stating I've never seen skin that bad before. During an interview on 11/12/21, at 2:53 p.m. the emergency department (ED) medical doctor (MD)-A stated when R1 arrived at the ED her incontinence brief was soaked and she had redness in her inner thighs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/12/21, at 3:49 p.m. licensed practical nurse (LPN)-A stated R1 was having difficulty with edema (swelling) and respiratory secretions the evening before she went to the hospital. LPN-A stated she informed the NA to monitor the number of incontinence brief changes because she received a diuretic (medication to increase urination) and they needed to monitor if it was effective. LPN-A stated she educated R1 on the need to change R1 throughout the night and R1 agreed she would let staff change her throughout the night; LPN-A informed the night nurses and nursing assistants of this. During an interview on 11/15/21, at 12:17 p.m. RN-B stated she was aware R1 had redness from incontinence and directed staff to use a barrier cream. RN-B stated R1 should be repositioned and checked for incontinence every three hours. RN-B stated the facility's routine was every two to three hours. During an interview on 11/15/21, at 3:10 p.m. the director of nursing (DON) stated the facility completed position logs (which included the residents incontinent status) if it made the family feel better, if residents were refusing turning, or if the resident had a bad wound; otherwise, there was no documentation of repositioning. She stated the expectation was for NA to document the position change and status of incontinence product, and then the nurse document in the EMR. If a resident refused, the DON stated she expected staff to document any behaviors and why refused on the log and then nurses would document in the progress note. The DON verified there was no documentation of refusals in R1's progress notes.