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	12/22/2022

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45843 Based on interview and document review the facility failed to report an allegation of neglect to the State Agency (SA) immediately and no later than 2 hours for 1 of 3 residents (R4) reviewed for abuse. Findings include: R4's fall incident report dated 12/5/22, at 4:43 p.m. identified R4 was being transferred from his motorized wheelchair to bed with a full body mechanical lift and two nursing assistants. During the transfer the lift tipped over and caused R4 to fall to the floor resulting in a head strike on bedside stand and two skin tears to left out wrist. Skin tears measured 2.25 centimeters (cm) X 2.25 cm X 2.25 cm x 1.0 cm. The predisposing environmental factors included the equipment. The lift was taken out of service. Review of the Facility Reported Incidents to the State Agency, did not include the fall from mechanical lift that caused injury to R4. During an interview on 12/20/22, at 9:27 a.m., R4 indicated he had fallen and hit his head during a lift transfer in his room a couple of weeks prior. He was being transferred from his wheelchair to his bed when the lift tipped over causing him to hit his head on his bedside table. During an interview on 12/20/22, at 10:27 director of nursing (DON) stated she was aware of the incident with R4 and the lift tipping over that caused injury to R4. DON verified the incident was not reported to the State Agency. Undated facility policy Resident Protection Plan included Reporting and Response: (continued on next page)

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.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employees must always report abuse immediately to the Administrator or designee. In response to allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Or no later than 24 hours if the events that cause the allegation do not involve abuse or result in serious bodily injury, to the Administrator of the facility and to their officials (including to the State Survey Agency and adult protective services where the state law provides for jurisdiction in the long-term care facilities) in accordance with state law through established procedures. The facility lacked evidence of the incident equipment failure being reported to the State Agency.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on observation, interview, and document review, the facility failed to ensure full body mechanical lifts were functioning properly with inspections/repairs according to manufacturer's recommendations for 2 of 4 residents (R4, R1) residents that used the full body lift on the 2-West unit. That resulted in R4 and R1 tipping and falling during full body lift transfer. This resulted in an immediate jeopardy for R4 and R1 for serious harm, injury, or death. In addition the facility failed to complete safe transfer assessments to determine appropriate sling size for 32 of 75 residents who used a full body lift. The immediate jeopardy began on 12/5/22, when R4 fell from a malfunctioning lift. The IJ was identified on 12/20/22, when R1 and R4 were transferred using a malfunctioning mechanical lift. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 12/20/22, at 4:49 p.m. The immediate jeopardy was removed on 12/21/22, at 4:10 p.m., but non-compliance remained at the lower scope and severity of (D) pattern scope and severity with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: R4's quarterly MDS dated [DATE], indicated R4 was understood and able to understand others, was cognitively intact, did not reject cares, and was completely dependent on staff for transfers and bed mobility. R4's transfer care plan dated 10/7/22, identified R4 required two staff assistance with full body mechanical lift with large blue sling. R4's incident progress report dated 10/5/22, indicated R4 was being transferred from wheelchair to bed with full body mechanical lift (Invacare Reliant 600) and two nurse aides (NA)'s. The lift tipped over with R4 onto the floor. R4 hit his head against the front of his bedside stand and sustained two skin tears to his left outer wrist measuring 2.25 centimeters (cm) X 2.25 cm and 2.25 cm x 1 cm. R4 stated the lift fell with him in it. The lift was taken out of commission. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation on 12/19/22, at 2:36 p.m. R4 sat in his chair in his room. NA-A and NA-B were preparing to transfer R4 from his wheelchair to his bed. R4 sat on a blue lift sling. NA-A went out of R4's room to get the lift (Invacare Reliant 450). When NA-A tried to push the lift, the wheels of the lift did not roll or turn easily. NA-A expressed frustration stating none of the lifts in the building work adequately and this was the only lift available for this unit. NA-A and NA-B connected the lift sling and raised R4 out of his chair. Once R4 was up in the air. NA-A attempted to push the lift over to R4's bed, however, the lift would not move easily. NA-A repeatedly shook the lift (pulling/pushing) it back in forth to get the lift to move to R4's bed. R4 was up in the sling swaying with the motion of the lift. NA-A pushed the legs of the lift under the bed; however, the wheels did not turn or roll. NA-A had to exert force to correctly align the lift underneath the bed so that R4 could be lowered to the bed. Once R4 was safely in bed, NA-A removed the lift from underneath the bed, again the wheels were observed to not roll or turn properly. NA-A and NA-B completed incontinent garment change and transferred R4 back to his chair with the same lift and difficulties maneuvering the lift. NA-A stated he had reported this lift function concerns to the nurses, but nothing had been done. During this observation NA-A or NA-B had not notified other staff, administration, or maintenance of the lift not rolling and difficulty manuvering while using this lift. R1's admission minimum data set (MDS) dated [DATE], indicated R1 was cognitively intact, had no rejections of cares, and was extensive assist with mobility. R1's care plan last reviewed 11/30/22, identified required total assist from two staff using full body mechanical lift for transfers. During an observation and interview on 12/20/22, at 8:45 a.m. R1 was transferred from her bed to her wheelchair using the same lift (Invacare Reliant 450) during R4's observation on 12/19/22. During the transfer the wheels of the lift were getting stuck preventing the lift from rolling with ease. NA-C reported this lift had frequent problems with the wheels. NA-C removed the lift from the room, placed it in the hallway for subsequent use. R1 explained recently (within the last couple of weeks), there was an incident while she was up in the air that was very startling to her and the staff. R1 reported she had been up in the air above her chair when the lift suddenly and without warning dropped her into her wheelchair. R1 could not recall which staff were there. R1 was glad she was not hurt and felt lucky she was not seriously injured. Review of R1's records and/or facility incident reports did not identify R1's incident with the lift malfunction of suddenly dropping. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 12/20/22, at 9:18 a.m. R4 sat in his electric wheelchair in his room. The same lift (Invacare Reliant 450) that was used during the aforementioned observations on 12/19 and 12/20/22. NA-B pushed the lift inside R4's room; again, the lift did not roll freely. NA-C stated the wheels were getting stuck because they were too big for the lift. The brakes also did not seem to work. NA-D entered the room explaining this lift was the only one for the entire 2nd floor. NAs attached R4's sling to the lift, raised R4 out of his chair. NA-B had to push/pull the lift back and forth to move the lift as the wheels did not roll without that action. The lift was positioned under the bed. As R4 was being lowered to the bed the lift started to tip over the left leg raised off the floor. NA-D stood on the left leg to prevent the lift from tipping. Both NA-C and NA-D stated the lift wheels and concerns had been reported to maintenance in the past however was unsure how many times this was reported. Both NA's indicated the lift has had ongoing issues without repair. During an interview on 12/20/22, at 10:48 a.m., NA-A stated he and NA-E had been the staff using the lift to transfer R4 that resulted in the fall on 12/5/22. NA-A explained the lift (Invacare Reliant 600) used on 12/5/22 had ongoing problems that had been reported; the lift was not rolling correctly, and the legs would open and move by themselves. NA-A reported he and NA-E had been transferring R4 from wheelchair to bed when the legs suddenly came off the floor causing the lift to flip over when R4 was in the air. NA-A reported the incident to nurse working and maintenance. The lift was removed from the floor after the incident. At 11:02 a. m. NA-E stated if there were concerns with the lift function he would report to the nurse. During an interview on 12/20/22, at 10:20 a.m. NA-C indicated the only lift available to use on the 2-West unit was the one used to transfer R1 and R4. The lift's wheels get stuck and does not roll easily. NA-C stated she had reported the issue to maintenance today, he looked at it and told her it was because the wheels were too big. NA-C indicated after looking at the lift, maintenance did not remove the lift from service and/or make repairs. During an interview on 12/20/22, at 11:32 a.m. director of maintenance (DOM) reported the Invacare 600 lift removed from service on 12/5/22 after the incident. The lift was inspected and found to have a bent frame. DOM indicated had not completed lift inspections monthly as directed by the manufacturer but completed the inspections every 6 months. DOM stated the facility currently had 3 different manufactures of lifts; EasyWay, Invacare, and Spam. DOM could not articulate how many lifts were in the building but three were out of service. DOM explained the only maintainance he could perform on the lift was checking the wheels and changing the batteries. DOM stated lifts were inspected by the manufacturer annually; last inspection was 5/2022. Three lifts were not inservice currently because they needed to be repaired. If lifts were broken or not working properly, he took them out of service immediately. DOM stated he was not aware of any issues or concerns with the lifts currently being used on the floor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 12/20/22, at 3:24 p.m. director of maintenance (DOM) DOM and licensed practical Nurse (LPN)-B inspected the Invacare Reliant lift used on 2 west. DOM stated the lift was not functioning properly. The wheels on the lift were too big; they were up against/hitting the metal hub and they should not be. The shift arm was broken, and a metal piece used to lock the shifter in place was broken off or missing. Additionally, the shift lever actuator was worn, and the spring was not locking into place causing the actuator arm not to bounce back into place. The spring not locking could cause a resident to fall. DOM explained, the lift should be put out of commission, but for right now until a new lift comes in, the lift will have to find a way to replace before it can be removed. During an interview on 12/20/22, at 2:11 p.m. licensed practical nurse (LPN)-A stated she could not tell what sling size to use because they did not have tags on them. Residents were not assessed for size slings they should use. So, we just eyeball it. During an interview on 12/20/22, at 2:17 p.m. LPN-C stated residents should be assessed by therapy for appropriate sling size, size should be identified on the care plan. However, during an interview on 12/20/22, at 3:46 p.m. physical therapist (PT) stated therapy was not doing evaluations to determine what size slings residents were supposed to use with lifts. PT was not aware who's responsibility that was. During an interview on 12/20/22, at 4:49 p.m. administrator and director of nursing (DON) stated an awareness of issues with the lifts for weeks and had been attempting to resolve the issue by obtaining more lifts for the facility. Administrator was aware the lift maintenance and inspections; inspections were due last month. Administrator thought there was a monthly preventative maintenance checklist for the lifts but would have to check into it. Request for preventative maintenance for facility lifts was requested; no records were made available that indicated monthly and semi annual inspections were completed in accordance with manufacturer recommendations. SLING USAGE AND ASSESSMENT R1's care plan reviewed 11/30/22, did not include what sling size R4 required for transfers with the full body lift. Further, there was no indication a safe transfer assessment was completed to identify appropriate sling size for R1. R4's transfer care plan dated 10/7/22, identified R4 required full body mechanical lift with large blue sling. During observations on 12/19/2 at 2:36 p.m. and on 12/20/22 at 9:18 a.m. R4 was transfered with a blue lift sling; however the manufacturer tag was missing from the sling, therefore the sling size or brand of sling could not be identified or confirmed. During an interview on 12/20/22, at 10:20 a.m. NA-C stated she was aware slings were specific to the brand of lift, however, the facility did not have the right slings for the right lifts. Residents kept the slings they used in their rooms. We used whatever sling they have in their room, with whatever lift there is available. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/20/22, at 2:11 p.m. LPN-A stated we could not tell what size sling to use, the slings did not have tags we just eye ball it. LPN-A explained to her knowledge has never assessed what size slings to use for the residents. During an interview on 12/20/22, at 2:17 p.m. LPN-C stated residents on 3 west are assessed for the size of the slings they need and it should be updated in the residents care plans. LPN-C stated therapy assesses for sling sizes. During an interview on 12/20/22, at 2:39 p.m. RN-A stated an unawareness of how to assess residents for the appropriate sling sizes. Further, RN-A could not articulate where, if anywhere, in the resident record appropriate sling size to use was documented. She used whatever sling was under the resident or in the residents room. NAs determined which slings the resident used. The size of the sling was on the tag; however, the tags were all worn off. RN-A stated the slings were kind of one size fits all. During an interview on 12/20/22, at 3:46 p.m. physical therapist (PT) stated therapy was not doing evaluations to determine what size or kind of slings residents were supposed to use with the lifts. We don't have anything to do with the size of the slings. PT was unaware who did or would complete the assessments. Request for Spam and EasyWay manufacturer's recommendations were requested and not received. A review of the user manual for the Invacare Reliant lift's 450 and 600-I included: -the shifter handle MUST lock into its mounting slot to keep the legs in the full closed position. Opening the legs, the shifter handle MUST lock into its mounting slot to lock the legs in the fully open position. WARNING If the shifter handle is not positioned completely into its mounting slot, DO NOT use the patient lift until the shifter handle is properly seated and the legs of the patient lift are locked in place. Otherwise, injury and/or damage may occur. -Warning the legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety. -Invacare slings are made specifically for use with Invacare Patient Lifts. For the safety of the patient, DO NOT use slings and patient lifts of different manufacturers. User manual also included Maintenance Safety Inspection Checklist for inspections that were required to be completed initially, monthly and by the manufacturer. The [NAME] Base Inspect for missing hardware, Base opens and closes with ease, inspect bolts for tightness, inspect casters for smooth swivel and roll, inspect and clear wheels of debris. This is to be done initially and monthly and in home inspection by manufacturer every 6 months. Shifter Handle (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Operates smoothly, locks adjustable base whenever engaged. This is to be done initially, monthly at institution and every 6 months by manufacturer. The Mast Mast MUST be securely assembled to boom. Inspect for beds or deflections. This is to be done initially, monthly at the institution, and every 6 months by the manufacturer. The manual/hydraulic pump/electric Actuator Check for leakage, inspect hardware on mast and boom, check for wear or deterioration. (If DAMAGED, RETURN TO FACTORY) The Boom, the Swivel Bar, The Pump Handle (ALL to be checked initially and monthly by facility and every 6 months by manufacturer) The manual further directed no adjustment or maintenance of either the casters or brakes, other than cleaning, lubrication and checking axle and swivel bolts for tightness. Remove all debris, etc. from the wheel and swivel bearings. If any parts are worn, replace these parts immediately. If you question the safety of any part of the lift, contact your Dealer immediately and advise him/her of your problem. The facility policy entitled, Lifting Machine, Using a Mechanical, Dated July 2017, did not identify procedures for malfunctioning lifts. The policy included, General Guidelines for lift use directed at least 2 nursing assistance were needed to safely move a resident with a mechanical lift. Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using specific machines or devices utilized in the facility. Directed staff to ensure the resident was measured for proper sling size according to manufacturer's instructions. Make sure the lift was working properly and the lift is stable and locked. The immediate jeopardy that began on 12/522, was removed on 12/21/22, at 4:10 p.m. when it was verified the facility implemented the following: -Removed Invacare 450 lift from service. -Inspected all mechanical lifts in service were safe and in proper working order. -Reviewed/revised notification procedures for malfunctioning equipment. -Provided education to maintenance personal on routine preventative maintenance and cleaning in accordance with manufacturer's recommendations -Developed and provided education to all nursing staff on lift malfunctions, removal of malfunctioning equipment from service, and reporting malfunctioning equipment.

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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** 45843 Based on observation, interview, and document review the facility failed to complete comprehensive bowel and bladder assessments and failed to provide toileting per the care plan to maintain or improve continence to the extent possible for 1 of 3 residents (R3) reviewed for activities of daily living. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 was frequently incontinent of urine and always incontinent of bowel, had severe cognitive impairment and did not have behaviors. MDS identified R3 had diagnoses of Cerebrovascular Accident (stroke) and hemiplegia or hemiparesis (weakness or inability to move on one side of the body). R3 required assistance with all activities of daily living. R3's record did not include a comprehensive bowel and bladder assessment that identified R3's type of incontinence (stress, urge, overflow, or mixed). R3's bowel and bladder care plan dated 11/15/22, identified R3's incontinence was related to impaired mobility. R3's goal was to have at least one continent episode daily. Corresponding intervention directed one staff member to assist R3 to the toilet every two hours and as needed. R3's record did not indicate and/or identify a completed assessment on how the every two hour toileting time was determined. During a continuous observation on 12/21/22, that began at 11:31 a.m. and ended 2:46 p.m. identified R3 was not toileted and/or offered toileting for 3.25 hours which was not in accordance with the care plan. -At 11:31 a.m. R3 was sitting in her wheelchair in the common area sipping on a can of Mountain Dew soda. -At 12:51 p.m. R3 continues to sit in the day room with a tray table in front of her holding a glass of brown liquid. -At 1:03 p.m. R3 sat in her wheelchair with a tray table in front of her, R3 removed her right leg from the wheelchair foot pedal. -At 1:09 p.m. R3 put her left hand on the left arm rest of her wheelchair, she attempted to push herself forward to lift her bottom up off the chair, however was unable. -At 1:19 p.m. an unidentified staff member asked R3 how she was doing, R3 responded better. The staff member did not offer and/or attempt to take R3 to the bathroom. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 1:32 p.m. R3 continues to sit her wheelchair in the common area room looking around the room. She was moving her feet off and on the wheelchair foot pedals and swinging her foot off to the side of the wheelchair. R3 pushed her weight against the foot pedals in attempt to lift bottom while leaning forward as if to stand up. -At 1:35 p.m., activity aide (AA)-A asked R3 if she would like to go to social activity and R3 did not respond. AA-A wheeled R3 to the large dining room. -At 1:55 p.m. R3 was demonstrated restless; playing with [NAME] that hung on another residents walker, shaking her foot and moving back and forth against the bottom of a counter area. R3 was pushing her foot up against the bottom of the counter, which moved her bottom around in the wheelchair. -At 2:02 p.m. AA-B asked R3 if she would like to go downstairs for affirmations. R3 did not respond. AA-B wheeled R3 to the blue activity room and placed in a semi-circle with other residents. At 2:12 p.m. R3 had restlessness, repeatedly leaned forward in her wheelchair, fidgeting with breaks on her wheelchair, and moving her wheelchair forward and outside the semi-circle of people. AA-A assisted R3 back to her place. -At 2:46 p.m. NA-A asked R3 if she wanted to be toileted to which R3 stated, yes. R3 was wheeled to her room and assisted to the commode. NA-A removed R3's incontinent garment which was wet and had been soiled with stool. NA-A assisted R3 onto the commode where she voided a moderate amount of urine. During an interview on 12/21/22, at 2:30 p.m. licensed practical nurse (LPN)-B reviewed the NA's toileting documentation sheet and reported, R3 was dry at 10:00 a.m., not toileted at 12:00 p.m. and wet at 2:00 p.m. LPN-B was not aware of the continuous observation that conflicted with the documentation by the nursing assistant. LPN-B indicated R3 was supposed to be toileted every 2 hours and as needed; NA's had not toileted per the care plan and should have. During an interview on 12/22/22, at 1:46 p.m. DON was unable to articulate facility policy and/or what constituted a comprehensive bladder assessment or how individualized toileting schedules were determined. The facility policy entitled, Activities of Daily Living (ADLs), Supporting, undated, stated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. A policy/protocol was requested for comprehensive bowel and bladder assessment was not provided.