



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 14, 2026

Administrator  
BAYSHORE RESIDENCE AND REHABILITATION CENTER  
1601 ST LOUIS AVENUE  
DULUTH, MN 55802

RE: CCN:245227

Cycle Start Date: June 26, 2026

Dear Administrator:

On June 26, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

**Alex Warren, Regional Operations Supervisor**  
**Duluth District Office**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**11 East Superior Street, Suite 290**  
**Duluth, MN 55082**  
**Email: [Alex.Warren@state.mn.us](mailto:Alex.Warren@state.mn.us)**

**Cell: 651-279-5375 Office: 218-302-6186**

## 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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by September 26, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 26, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.**

## **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

## **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens  
State Fire Safety Supervisor  
Health Care & Correctional Facilities  
MN Department of Public Safety-Fire Marshal Division  
445 Minnesota St., Suite 145  
St. Paul, MN 55101  
Email: [travis.ahrens@state.mn.us](mailto:travis.ahrens@state.mn.us)  
Web: [www.sfm.dps.mn.gov](http://www.sfm.dps.mn.gov)  
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health



P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308    Fax: 651-215-9697

Email: [sarah.lane@state.mn.us](mailto:sarah.lane@state.mn.us)





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1601 ST LOUIS AVENUE  
DULUTH, MN 55802

Re: State Nursing Home Licensing Orders

Event ID: 231C41-H1

Dear Administrator:

The above facility survey was completed on June 26, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction 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 deficiency. Please remember that this provision is only a suggestion 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 order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html). The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

**Alex Warren, Regional Operations Supervisor**  
**Duluth District Office**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**11 East Superior Street, Suite 290**  
**Duluth, MN 55082**  
**Email: [Alex.Warren@state.mn.us](mailto:Alex.Warren@state.mn.us)**

**Cell: 651-279-5375 Office: 218-302-6186**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst



Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308    Fax: 651-215-9697

Email: [sarah.lane@state.mn.us](mailto:sarah.lane@state.mn.us)



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245227 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                     |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>06/26/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                          |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                              | (X5)<br>COMPLETION<br>DATE |
| E0000                                                                            | Initial Comments<br><br>On 6/22/26-6/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  | E0000                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |
| F0000                                                                            | INITIAL COMMENTS<br><br>On 6/22/26-6/26/26, a standard recertification survey (S5227041-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed without citation: H52273099C (3006525), H52273100C (3022363), H52272793C (3035178), H52272819C (3035998).<br><br>The following complaint was reviewed H52273101C (1099878) with citation at (F804).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. |                                                                  |  | F0000                                                                                        |                                                                                                                          |                                              |                            |

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 reverse for further 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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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                            |
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| F0761<br>SS = E                                                                  | <p>Label/Store Drugs and Biologicals</p> <p>CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to properly dispose of medications in the second-floor medication storage room. This had the ability to affect any resident who received medications from the second-floor medication storage room.</p> <p>Findings include: During a tour of the second-floor medication room with licensed practical nurse (LPN)-D on 6/25/26 at 9:23 a.m., multiple medications were observed to be expired. LPN-D stated that he wasn't sure of the process to remove the expired medications and I would have to follow up with director of nursing (DON). LPN-D stated that a lot of the medications in the medication storage room were overflow. Expired medications included the following: -saline nasal gel, expired 4/28/25-magnesium chloride, expired 4/9/26-docusate sodium, expired 12/4/25-cephalaxin, filled 9/16/25-Tylenol assigned to R19, expired 6/18/25. During an interview on 6/25/26 at 12:34 p.m., the director of nursing (DON)</p> |                                                                  |  | F0761                                                                                        | <p>All medications stored in the second-floor medication storage room were immediately reviewed. Any expired, discontinued, or otherwise non-reusable medications identified were removed from active stock and disposed of in accordance with facility policy and applicable regulations.</p> <p>All medication storage rooms throughout the facility were audited to ensure medications were properly stored and that expired or discontinued medications had been appropriately removed and disposed of. Any discrepancies identified during the audit were corrected immediately.</p> <p>Licensed nursing staff responsible for medication management were in-serviced on the Discarding/Destroying Medication Policy with emphasis on #5c that when a discontinuation order is received from the provider, the medication must be destroyed. The facility will reinforce expectations regarding routine medication storage inspections and compliance with regulatory requirements.</p> <p>The Director of Nursing is responsible for Compliance.</p> <p>Audits on medication storage rooms weekly for four weeks, followed by monthly audits for two months to verify compliance with medication disposal procedures. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program, and corrective action will be implemented promptly if concerns are identified.</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| F0761<br>SS = E                                                                  | Continued from page 2<br>stated the nurse managers, or her audit medication carts monthly, but she had not audited the second-floor medication storage room. The expectation would be that nurses would put the expired medications in in the medication disposal bank on the first floor. Facility policy, Storage of Medications, undated, identified that discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  |  | F0761                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              | 08/07/2026                 |
| F0804<br>SS = E                                                                  | <p>Nutritive Value/Appear, Palatable/Prefer Temp</p> <p>CFR(s): 483.60(d)(1)(2)</p> <p>§483.60(d) Food and drink</p> <p>Each resident receives and the facility provides-</p> <p>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to ensure meals were palatable for 8 of 14 residents (R17, R12, R10, R4, R5, R58, R61, R81) who expressed dissatisfaction with palatability of meals. In addition, the facility failed to ensure the temperature of foods was maintained when transported to resident rooms.</p> <p>Findings include:</p> <p>R17's quarterly Minimum Data Set (MDS) dated 6/11/26, identified R17 was moderately cognitively intact.</p> <p>During an interview on 6/22/26 at 2:30 p.m., R17 stated the food was "pretty much terrible".</p> <p>During an observation on 6/24/26 at 1:02 p.m., R17 was no longer in the main dining room. He had eaten only a few bites of the meal which was a French dip sandwich, French fries, and a creamy cucumber salad.</p> <p>R12's quarterly MDS dated 6/1/26, identified R12 was cognitively intact.</p> <p>During an interview on 6/22/26 at 3:15 p.m., R12 stated the food was poor quality, said the cooks</p> |                                                                  |  | F0804                                                                                        | <p>R12, R17, R10, R4, R5, R58, R61 and R81 will meet with dietary manager, a grievance form completed along with a Resident Dietary Preference form completed. All current residents will have a completed resident dietary preference. There were no adverse effects experienced by any resident within the facility. Future resident admissions, a resident preference form will be completed, and meals will be cooked per food vendor recipe and sampled per facility policy.</p> <p>Dietary staff were in-serviced on the Standardized Recipe policy (1-6) with emphasis on following the meal preparation instructions for each menu item and if recipe issues arise, the cook and dietary manager will discuss those issues for resolution. The Dietary manager and cook will also be in-serviced on the Taste testing policy (3-38) that instructs all meals will taste tested prior to serving and all meals not passing the taste test due to seasoning, toughness, color or other negative factors will not be served until the problem is rectified. Lastly, temps will be taken on pre-and-post delivery of meals to ensure food temperature is within proper range.</p> <p>The Dietary manager or designee is responsible for compliance.</p> <p>Audits on meal preparation/following recipe, taste testing, pre/post temps, resident satisfaction and consistency will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review, and additional corrective actions will be implemented as needed to maintain compliance.</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                          |                                              |                            |
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| F0804<br>SS = E                                                                  | <p>Continued from page 3</p> <p>didn't know how to cook, and went on to state the hot food was not hot, and ice cream was served melted. R12 stated they were also not able to get oil and vinegar for a salad.</p> <p>During an observation and interview on 6/23/26 at 12:55 R12 stated she had not received any dressing for the salad. The meal was nacho chicken, shredded lettuce and tomato, refried beans, corn, and frosted marble cake.</p> <p>R10's quarterly MDS dated 5/29/26, identified R10 was cognitively intact.</p> <p>During an interview on 6/22/26 at 12:45 p.m., R10 stated the eggs were served cold and overcooked. R10 stated there was no variety and no seasoning.</p> <p>During an observation and interview on 6/23/26 at 12:59 p.m., R10 had a lunch of chicken breast, corn, refried beans, he touched his food and stated it was cold.</p> <p>R4's quarterly MDS dated 6/4/26, identified R4 was cognitively intact.</p> <p>During an interview on 6/22/26 at 5:33 p.m., R4 stated the food had gone "downhill", the hot food was not hot, and the cold food was not cold.</p> <p>R5's quarterly MDS dated 3/31/26, identified R5 was cognitively intact.</p> <p>During an interview on 6/22/26 at 3:00 p.m., R5 stated that lots of the food was "bad".</p> <p>R81's quarterly MDS dated 6/11/26, identified R81 was cognitively intact.</p> <p>During an interview on 6/22/26 at 1:11 p.m., R81 stated the food was "awful", no taste for the potatoes, the chicken was dry and in general the food was overcooked.</p> <p>During an observation and interview on 6/23/26 at 1:00 p.m., R81 stated his food was "awful", staff had removed it to reheat it.</p> <p>During an observation on 6/23/26 at 12:20 p.m., a speed cart arrived with a plastic covering. The entrees were covered as were the beverages.</p> <p>At 12:27 p.m., staff added coffee to cups and placed them on the meal trays</p> |                                                                  |  | F0804                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| F0804<br>SS = E                                                                  | <p>Continued from page 4</p> <p>At 12:30 p.m., staff began passing out the meal trays to the residents who were eating in their rooms</p> <p>At 12:41 p.m., a second tray arrived on another hallway with a plastic covering, staff performed hand hygiene and began passing out the meal trays to resident who were eating in their rooms</p> <p>During an interview on 6/26/26 at 8:15 a.m., the director of nursing (DON) stated they were aware of the food complaints since February.</p> <p>R58's quarterly Minimum Data Set (MDS) dated 4/16/26, identified R58 was cognitively intact.</p> <p>R61's quarterly MDS dated 3/26/26, identified R61 was cognitively intact.</p> <p>During an observation on 6/24/26 at 12:44 p.m., lunch trays were being delivered to resident rooms from an open ladder rack with plates in insulated serving dishes and milk cartons on the tray. The culinary director (CD) took temperatures on the last room tray served. The roast beef on a bun was 100.4 degrees Fahrenheit (F), the cup of au jus was 106.5 degrees F, and the carton of milk was 54.3 degrees F.</p> <p>During an interview on 6/24/26 at 12:44 p.m., CD confirmed the temperatures of foods on the last tray served were not what they expected for food quality. They stated their main concern was related to quality and palatability, and indicated safety would be a concern if it had been greater than 2 hours.</p> <p>During resident council interview on 6/25/26 at 9:57 a.m., R58 and R61 indicated the food concerns had not been fully addressed. They stated food quality and temperature were not great, food was always cold when eating in their room, and cold food was not always reheated by staff when requested.</p> <p>During an interview on 6/25/26 at 10:33 a.m., activity director (AD), indicated they were aware of the cold food concerns. They brought all food concerns to Quality Assurance and Performance Improvement (QAPI) and the food department manager.</p> <p>During an interview on 6/26/26 at 8:45 a.m., the director of nursing (DON) stated they expected trays</p> |                                                                  |  | F0804                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| F0804<br>SS = E                                                                  | <p>Continued from page 5<br/>delivered to resident rooms were hot, and cold items cold. They had concerns about food quality.</p> <p>Review of Resident Council meeting minutes:</p> <p>Resident Council Meeting minutes dated 2/12/26 at 10:00 a.m., with 18 residents attending, indicated concerns about cold food and needing staff to reheat the food.</p> <p>Resident Council Meeting minutes dated 4/9/26 at 10:00 a.m., with 15 residents attending, indicated residents were asked for any concerns, compliments, or suggestions for dietary.</p> <p>Resident Council Meeting minutes dated 6/11/26 at 10:00 a.m., with 22 residents attending, indicated concerns about food quality including food being overcooked and rubbery.</p> <p>Food Temperatures policy dated 2026, instructed that foods sent to the units for distribution will be transported and delivered to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods.</p> |                                                                  |  | F0804                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                              | 08/07/2026                 |
| F0812<br>SS = E                                                                  | <p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p>                                                                                                                                                                                                                                                        |                                                                  |  | F0812                                                                                        | <p>The three-compartment sink was used until temperature gauge was repaired. Dishwasher temperature gauge was replaced on 6/25/2026. There were no ill effects experienced by this deficient practice. All chemical containers and open boxes in the closet were cleared and items organized and area secured. Employees without proper facial hair coverings were donned immediately when notified by the state surveyor. There were no adverse effects experienced by any resident within the facility.</p> <p>Dietary staff were in-serviced on the Food Safety Policy with emphasis on item #2 that all staff are required to have their hair styled so that it does not touch the collar, hair restraints are required and beard nets are required when facial hair is visible. In addition, the dietary staff were in-serviced on the Equipment Malfunctions and Repairs Policy (6-22) with emphasis on notifying the dietary director and maintenance when equipment malfunctions and on the Cleaning Dishes Using a Dish Machine (4-12) item #1 that prior to use, proper temperatures and/or chemical concentrations and machine function should be verified and the Dish Machine Log (4-14) must be completed for wash and rinse cycles at</p> |                                              | 08/07/2026                 |



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| F0812<br>SS = E                                                                  | <p>Continued from page 6</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to consistently track and monitor dishwasher temperatures for both the wash and rinse cycles, and take timely action to correct the temperatures, for 1 of 1 dishwasher. This had the potential to affect all current residents, as well as staff or visitors, who ate food served from dishes and tableware that were cleaned in the dishwasher. Additionally, the facility failed to ensure proper sanitary storage of cleaning products and personal protective equipment and failed to ensure staff appropriately covered facial hair.</p> <p>Findings include:</p> <p>Dishwasher temperatures:</p> <p>During an observation on 6/25/26 at 9:38 a.m., dietary aide (DA)-A was operating the dirty side of the dishwasher and DA-B was removing dishes on the clean side of the dishwasher. DA-A completed a wash cycle. On the dishwasher, the rinse temperature was observed to be 180 degrees Fahrenheit (F), and the wash temperature gauge was not functioning.</p> <p>During an interview on 6/25/26 at 10:11 a.m., DA-A stated dishwasher temperatures were logged by staff working the clean side of the dishwasher every shift. DA-A started a wash cycle, observed the temperature gauges, and confirmed the wash temperature gauge was not functioning. DA-A stated this was not good because the wash temperature was not known.</p> <p>During an observation on 6/25/26 at 10:15 a.m., dishwashing logs for May 2026 and June 2026 were reviewed and included columns labeled wash and rinse for each meal. The June 2026 dishwashing temperature log had no temps logged for all meals 15 out of 25 days, no temps were logged for dinner, and all recorded breakfast rinse temps were logged below 180 degrees F, ranging from 170-175 degrees F, with no follow-up notations. The May 2026 dishwashing temperature log had no temps logged for all meals 23 out of 31 days and no temps were logged for dinner.</p> <p>During an interview on 6/25/26 at 10:17 a.m., cook (C)-A reviewed the dishwasher temperature logs for</p> |                                                                  |  | F0812                                                                                        | <p>Continued from page 6</p> <p>each meal. Lastly, the dietary team will be in-serviced on the Dry Storage Areas Policy and procedure that instructs that poisonous and toxic material will be store outside the food storage area in cabinets and that the storeroom will be cleaned on a regular basis.</p> <p>Dietary Manager or designee is responsible for compliance.</p> <p>Audits on hair coverings, storage area cleanliness and dish temperature recording 2x week for 3 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit findings will be reviewed during the Quality Assurance and Performance Improvement (QAPI) meeting, and corrective actions will be implemented for any identified deficiencies.</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| F0812<br>SS = E                                                                  | <p>Continued from page 7</p> <p>May 2026 and June 2026. C-A confirmed that temperatures were not logged consistently, and several recorded rinse temperatures were below 180 degrees F and was concerned that dishes were not heated for proper sanitation.</p> <p>During an interview on 6/25/26 at 10:19 a.m., DA-B stated dishwasher temperatures were logged every shift. DA-B confirmed they had not logged the morning temperatures and stated they were running late that morning.</p> <p>During an interview on 6/25/26 at 10:29 a.m., culinary director (CD) observed the dishwasher running and confirmed the wash temperature gauge was not moving and the rinse temperature was 175 degrees F. CD asked DA-B about the wash gauge and DA-B stated, "sometimes it works, sometimes it doesn't." CD was concerned that if the dishwasher was not reaching appropriate temperatures, it may not be killing germs. CD stated they expected staff to log temperatures twice daily and let them know if there were issues. CD stated the dishwasher was leased from Ecolab, they needed to call for service, and asked staff to use the 3-compartment sink until it was resolved.</p> <p>During an interview on 6/25/26 at 12:55 p.m., Ecolab technician identified the dishwasher as a high-temperature dishwasher and confirmed the wash temperature gauge had failed. They stated the minimum wash temperature for the machine was 160 degrees F and the minimum rinse temperature was 180 degrees F. They identified during their service call on 6/25/26, a T60 test strip applied to a ceramic plate during dishwasher run had turned black which verified the dish reached 160 degrees F and was sanitized.</p> <p>The dishwasher temperature gauges indicated wash temperature minimum was 160 degrees F and rinse temperature minimum was 180 degrees F.</p> <p>A copy of dishwashing logs for May 2026 and June 2026 were requested but not received.</p> <p>Cleaning Dishes Using a Dish Machine policy dated 2026, instructed that proper temperatures and machine function should be verified prior to use, and staff should check the dish machine gauges throughout the cycle to ensure proper temperatures for sanitation. It identified for a high-temperature dishwasher that the wash cycle reaches 150 to 165 degrees F and the rinse cycle reach 180 degrees F.</p> <p>Ecolab manufacturer instructions dated 2020,</p> |                                                                  |  | F0812                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| F0812<br>SS = E                                                                  | <p>Continued from page 8</p> <p>identified the following water temperature requirements:</p> <p>Wash temperature (hot water sanitizing) 160°F</p> <p>Rinse temperature (hot water sanitizing) 180°F</p> <p>Sanitary Storage:</p> <p>During a kitchen observation on 6/25/26 at 9:45 a.m., a closet between the kitchen and the entrance to the dirty side of the dishwasher was observed to be open and disorganized with open chemical containers, open boxes of gloves, and more than a dozen flies swarming and landing on the closet contents.</p> <p>During an interview on 6/25/26 at 10:36 a.m., CD observed the closet and stated they had not seen the closet before as they were new to the facility. CD identified the open chemicals as partially full Ecolab Solitaire dish detergent. CD stated they expected the closet to be closed, organized, and the chemical containers covered. CD had concerns for contamination from the flies.</p> <p>Chemical storage policy, personal protective equipment storage policy, and pet control policy were requested but not received.</p> <p>Facial Hair:</p> <p>During a kitchen observation on 6/25/26 at 11:50 a.m., other kitchen staff (O)-D was placing fruit and dessert cups on resident trays on a ladder rack. O-D was observed to have a full beard and mustache that were not covered with a facial hair net.</p> <p>During an interview on 6/25/26 at 11:50 a.m., O-D stated hairnets are required for facial hair, confirmed they should have a hairnet covering their beard, and stated the concern was for hair falling into the food.</p> <p>During an interview on 6/25/26 at 12:37 p.m., CD stated hair nets are required if facial hair was long enough to grab. CD was concerned for hair falling into food and possibly carrying pathogens if facial hair was not covered while serving food.</p> |                                                                  |  | F0812                                                                                        |                                                                                                                                                                                                                                                                                                                                                           |                                              | 08/07/2026                 |
| F0552<br>SS = D                                                                  | <p>Right to be Informed/Make Treatment Decisions</p> <p>CFR(s): 483.10(c)(1)(4)(5)</p> <p>§483.10(c) Planning and Implementing Care.</p> <p>The resident has the right to be informed of, and</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  | F0552                                                                                        | <p>The attending physician and interdisciplinary team reviewed Resident #2's psychotropic medication regimen. The resident and/or the resident's responsible party were informed of the purpose, benefits, risks, and potential side effects of the prescribed medication, and informed consent was obtained and documented in the medical record. If</p> |                                              | 08/07/2026                 |



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| F0552<br>SS = D                                                                  | <p>Continued from page 9<br/>participate in, his or her treatment, including:</p> <p>§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.</p> <p>§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure residents were informed of and consented to medications prescribed and given for mental health intervention for 1 of 5 residents (R2) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R2's quarterly Minimum Data Set (MDS) dated 4/1/26, identified R2 was cognitively intact.</p> <p>R2's diagnoses included heart failure, renal insufficiency, schizoaffective disorder, non-Alzheimer's dementia, and arthritis.</p> <p>R2's care plan dated 6/26/26, identified R2 uses psychotropic medications related to behavior management. R2's provider orders dated 8/18/25, included mirtazapine oral tablet 15 mg: Give 15 mg by mouth at bedtime for depression. R2's provider orders dated 8/19/25, included risperidone oral tablet 0.5 mg: Give 1 tablet by mouth two times a day for mood disorder.</p> <p>R2's Informed Consent for Required Medications dated 2/5/24, for risperidone 2.5 mg two times a day for bipolar, was signed by R2.</p> <p>R2's medical record had no Informed Consent for Required Medications for mirtazapine.</p> <p>During interview on 6/26/26 at 9:06 a.m., director of nursing (DON) stated consents for psychotropic medications were obtained by a resident's</p> |                                                                  |  | F0552                                                                                        | <p>Continued from page 9<br/>applicable, the physician was notified of any concerns, and the resident's care plan was updated to reflect the intervention.</p> <p>All current residents who are receiving psychotropic medications their consents were reviewed and/or updated verifying that informed consent had been obtained and documented in the medical record. Any missing or incomplete consent documentation was obtained promptly and filed in the resident's record.</p> <p>Admission Coordinator, Licensed nurses, Social Service Department and facility provider group were in-serviced on the Antipsychotic facility's policy and procedure on obtaining consent and recording the consent in the medical record.</p> <p>Director of Nursing is responsible for compliance.</p> <p>Audit on all new psychotropic medication orders will begin weekly for four weeks, then monthly for two months, to ensure informed consent has been obtained and documented prior to or promptly following initiation of therapy, as appropriate. Audit findings will be reviewed during the Quality Assurance and Performance Improvement (QAPI) meeting, and corrective actions will be implemented for any identified deficiencies.</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| F0552<br>SS = D                                                                  | <p>Continued from page 10</p> <p>physician, and nursing staff should ensure the consents were in the medical record. DON stated the physician should be updating the consents when prescribing new medications. DON confirmed R2 had no consent for mirtazapine in their medical record, and stated concern for lacking informed consent from R2.</p> <p>Antipsychotic Medication Use policy dated 4/26/2025, instructed that the resident record must include provider diagnosis, indication for use and documentation that the resident acknowledged consent to receive prescribed psychotropic medications.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |  | F0552                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              | 08/07/2026                 |
| F0554<br>SS = D                                                                  | <p>Resident Self-Admin Meds-Clinically Approp</p> <p>CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure that a resident who was assessed to be unable to self-administer medications did not self-administer nebulizer treatments. This affected 1 of 1 resident (R8) reviewed for self-administration of medication.</p> <p>Findings include: R8's quarterly Minimum Data Set (MDS) dated 4/22/26, identified R8 as cognitively intact. Diagnosis included chronic obstructive pulmonary disease (COPD) and rheumatoid arthritis (RA). R8's MDS further indicated that she was assessed as unable to self-administer medications. R8's current orders, reviewed 6/24/26, included Albuterol Sulfate Inhalation Nebulization Solution 2.5 milligrams (mg), inhale orally three times a day. Current orders failed to indicate R8 was able to self-administer medications. During observation on 6/24/26 at 11:00 a.m., R8's nebulizer sat atop her bedside table with noted droplets in the nebulizer chamber. During interview on 6/24/26 at 11:47 a.m., R8 stated that she uses her nebulizer three times daily. Staff sets it up and I turn it on. They don't come back to clean it. During interview on 6/24/26 at 12:24 p.m., registered nurse (RN)-F stated that she can't say the last time she passed meds on R8's unit, but if they can self-administer medications it should show on the medication administration record (MAR) or in their orders. During interview on 6/24/26 at 1:12 p.m., trained</p> |                                                                  |  | F0554                                                                                        | <p>R8 who had medications at the bedside had a new Self-administration of Medication assessment completed and from this assessment, the MD was notified of the results. All current residents were reviewed for self-administration of medication, and their assessment, care plan and IDT discussion documentation were reviewed and updated as needed Future resident admissions, residents who express interest in self-administration of medication, the IDT team will initiate a self-administration assessment per facility policy.</p> <p>The IDT team along with Licensed Nurses was in-serviced on the Self-Administration of Medication Policy with emphasis on item #5 that the facility will initiate a self-administration medication assessment after a resident expresses the desire to and demonstrates the ability to safely self-administer specific medication(s).</p> <p>Director of Nursing and/or designee is responsible for sustained compliance.</p> <p>Audits on Self-Administration assessment completion, care plan, progress note and return demonstration by the resident will be audited weekly x 3 weeks, then monthly to ensure sustained compliance.</p> <p>Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| F0554<br>SS = D                                                                  | Continued from page 11<br>medication aide (TMA)-A stated that she sets up R8's nebulizer, R8 completes the treatment, and she later goes back to clean the nebulizer. There are currently three people on this unit that can self-administer oral medications once set up, and R8 is not one of them. Residents usually have a separate order to self-administer nebulizers themselves. On 6/25/26 at 12:38 p.m., the director of nursing (DON) confirmed that R8 was assessed as unable to self-administer medications and there was not a current order for R8 to self-administer medications. The DON stated the expectation would be that a resident would have a SAM assessment indicating that they can self-administer an albuterol nebulizer. Facility policy, Self-Administration of Medications, undated, identified "If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluates options which allow residents to safely participate in the medication administration process if they wish to do so. "                                                                                                                |                                                                  |  | F0554                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              | 08/07/2026                 |
| F0677<br>SS = D                                                                  | ADL Care Provided for Dependent Residents<br><br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to honor shaving preferences and needed assistance for 1 of 1 residents (R112) who required minimal assistance with shaving and oral care.<br><br>Findings include:<br><br>R112's admission Minimum Data Set (MDS) dated 6/22/26, status: ready for export, indicated R112 was cognitively intact with the diagnoses of encounter for orthopedic after care, kidney disease, diabetes, congestive heart failure and muscle weakness. Section GG indicated R112 required setup or clean-up assistance for personal hygiene including shaving and oral hygiene.<br><br>R112's care plan last updated dated 6/23/26, did not include R112's general preferences or activities of living (ADL) preferences. The Focus area Functional Discharge Goals included: hygiene goal: set up or clean up assistance with personal hygiene. |                                                                  |  | F0677                                                                                        | R112 was shaved per resident preference. R112 care plan preference was updated with shaving preference and frequency. All current residents who require assistance for shaving, their care plans were reviewed and updated as needed. Future residents who are dependent on ADL's, their care plans will be developed and interventions initiated.<br><br>Licensed nurses and nurse aides will be in-serviced on the ADL support policy with focus on item #2 that appropriate care and services will be rendered for residents who are unable to carry out ADLs independently.<br><br>DON and/or designee is responsible for compliance.<br><br>Audits on grooming (bathing, nail care, hair care and shaving) will begin weekly x 2 weeks then monthly to ensure sustained compliance.<br><br>Audit results will be reviewed by the Administrator, and the Administrator will take the audit results to QAPI for review and recommendation.<br><br>Compliance: August 7, 2026 |                                              | 08/07/2026                 |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245227 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                     |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>06/26/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                          |                                              |                            |
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| F0677<br>SS = D                                                                  | <p>Continued from page 12</p> <p>The oral hygiene goal identified was to be independent with oral hygiene.</p> <p>On 6/22/26 at 2:04 p.m., R112 stated staff had not offered to help them get set up to brush their teeth, they had to ask them to help, or it wouldn't get done. R112 touched their face and said they hadn't been able to shave since they got to the facility. They had asked multiple staff but so far nobody had helped them. R112 explained at home they only kept a goatee, and they didn't want all the new whiskers as they were itchy. R112 wanted to be cleaned shaved just like they were at home. It was noted R112 had significant whisker stubble on their face and under their chin.</p> <p>During an interview on 6/24/26 at 9:09 a.m., R112 was noted to have significant whisker growth on the face and neck outside of their goatee. R112 stated they had not been able to shave yet, they had now been waiting three days for help. R112 stated they had asked for help once today, three times yesterday, and multiple times the day before that. R112 thought they had asked at least three or four different staff for assistance. Today, staff had said they were working on it, but nothing had happened yet.</p> <p>During an interview on 6/24/26 at 1:19 p.m., nursing assistant (NA-A) stated the facility had disposable razors that could be used to shave a resident if they didn't have their own shaver or razors. NA-A stated if a resident asked to be shaved staff should do it.</p> <p>During an interview on 6/24/26 at 1:45 p.m., registered nurse manager (RN-D) stated resident preferences were looked at during admission by the charge nurse. In addition, RN-D indicated they and the social worker did a meet and greet with the resident and reviewed their preferences which included shaving and oral care. RN-D stated they would expect shaving to get done when a resident asked.</p> <p>During an interview on 6/25/26 at 9:20 a.m., NA-D stated as NA's they did shave residents. We ask residents if they want to be shaved and then we do it if that is what they wanted. Stock supply razors would be used if a resident did not have their own razor or shaver.</p> <p>During an interview on 6/25/26 at 9:23 a.m., R112 continued to have whisker growth on their face and neck. R112 stated staff had not offered to assist them with brushing their teeth or with getting shaved yesterday or today even after they had asked to</p> |                                                                  |  | F0677                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| F0677<br>SS = D                                                                  | <p>Continued from page 13</p> <p>shave yesterday. They really needed to shave because they were sick of their face constantly being itchy.</p> <p>During an interview on 6/25/26 at 2:12 p.m., RN-D, stated staff should be setting up and offering assistance with ADLs to residents who have triggered for some level of assistance on the MDS.</p> <p>During an interview on 6/25/26 at 3:03 p.m., the director of nursing (DON) stated when a resident requested to shave, they expected staff to assist the resident to shave as soon as able the same day. They also expected staff to go in and offer assistance and or set up residents so they could shave/brush their teeth themselves. If residents were not doing those things for themselves, the DON expected staff to complete those cares without having to be asked by residents.</p> <p>The facility policy Activities of Daily Living (ADLs), Supporting dated 6/25/26, instructed residents will be provided with care, treatment and services as appropriate, to maintain or improve their ability to carry out activities of daily living. Services identified included bathing, dressing, grooming, and oral care.</p> <p>The facility policy Resident Rights dated 7/14/21, identified that residents had the right to self-determination.</p> |                                                                  |  | F0677                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              | 08/07/2026                 |
| F0689<br>SS = D                                                                  | <p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure a resident could smoke safely for 1 of 1 resident (R10) reviewed for safe smoking.</p> <p>Findings include:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |  | F0689                                                                                        | <p>R10 had a new smoking assessment completed and R10's care plan was reviewed and updated as needed. R10 will be offered the ability to purchase smoke retardant clothing and will continue to work with therapy to find potential adaptive equipment. Current residents who smoke, their assessments and care plans were reviewed and updated as needed. Future residents who smoke will have a smoking assessment completed and appropriate care plan interventions implemented.</p> <p>Facility staff will be in-serviced on the Smoking Policy which indicates in item # 9 that smoking privileges may be revoked if it is determined that the resident is unsafe to smoke independently. Residents who smoke will also be educated at the next resident council meeting tentatively scheduled for August 6, 2026 on the Smoking Policy.</p> <p>Director of Nursing is responsible for compliance.</p> <p>Audits on resident audit all residents with smoking privileges that their smoking assessments are current, care plans reflect appropriate interventions, and required supervision is being provided will begin</p> |                                              | 08/07/2026                 |



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| F0689<br>SS = D                                                                  | <p>Continued from page 14</p> <p>R10's quarterly Minimum Data Set (MDS) dated 5/29/26, identified R10 was cognitively intact and had no rejections of care. In addition, R10's MDS identified he required set up for eating and was dependent on staff for activities of daily living.</p> <p>R10's Diagnosis Report dated 6/26/26, identified R10 had diagnoses which included heart failure (a condition where the heart muscle is too weak or too stiff to pump blood efficiently), lymphedema (a chronic condition characterized by the abnormal buildup of protein-rich lymph fluid, which causes swelling [edema] in the body's soft tissues), cellulitis of left finger, acquired absence of left finger(s), burn of unspecified degree of multiple sites of left and right wrist and hand, diabetes mellitus, open wound of left middle finger, open wound of left ring finger.</p> <p>R10's Medication Review Report dated 6/26/26, identified R10 had orders for dressing changes to left hand wounds twice daily and as needed for nonadherence/soilage. "Cleanse left hand wounds with wound cleanser. Then apply collagen and gauze, secure with Coban."</p> <p>R10's care plan dated 1/7/26, identified R10 as using tobacco. Interventions included to determine if he had a desire to quit smoking, to educate on the risks and health effects of tobacco use, to provide education regarding the adverse effects of smoking, to provide resources on smoking cessation, and to provide with a cigarette holder to use while smoking. In addition, R10's care plan identified current functional performance as follows:</p> <p>"Resident uses soft touch call light due to limited dexterity in both hands", dated 5/28/26</p> <p>"Dressing – Total assist" dated 3/18/25</p> <p>"Eating – Independent/ set-up help only" dated 3/14/25</p> <p>R10's smoking assessment dated 6/18/26, identified he smoked 6-10 cigarettes daily, had medical contraindications to smoking, and was able to safely hold, light, smoke, extinguish the cigarette and secure lighter in a safe manner without assistance. Question six related to prior to the start of the observation, does the resident have existing burn holes in clothing, it was answered "no". Question seven related to burns or holes in clothing from falling ashes was answered as "no". The conclusion included the following interventions, smoking apron, smoking materials kept at the nurse's station.</p> |                                                                  |  | F0689                                                                                        | <p>Continued from page 14</p> <p>weekly for 2 weeks, then monthly to ensure sustained compliance.</p> <p>Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation.</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| F0689<br>SS = D                                                                  | <p>Continued from page 15</p> <p>R10's smoking assessment dated 5/26/26, identified he smoked 10-20 cigarettes daily, had medical contraindications to smoking, and was able to safely hold, light, smoke, extinguish the cigarette and secure lighter in a safe manner without assistance. Question six related to prior to the start of the observation, does the resident have existing burn holes in clothing, it was answered "yes". Question seven related to burns or holes in clothing from falling ashes was "yes". The conclusion included the following interventions, adaptive equipment and smoking apron. It also included he had been provided with a cigarette holder and smoking apron for use during smoking.</p> <p>R10's smoking assessment dated 5/7/26, identified he smoked 5-10 cigarettes daily. Question two related to any medical contraindications to smoking was answered as "no". Question six related to prior to the start of the observation, does the resident have existing burn holes in clothing, it was answered "yes". Question seven related to burns or holes in clothing from falling ashes was "yes". Question nine related to an accident related to smoking was answered "yes". Interventions included adaptive equipment, smoking apron, smoking materials kept at nurse's station and violated smoking policy – will reassess per plan. Included he would not use a smoking apron. He signed a risk versus benefit, on 4/11/26, identifying he understood the risks associated with smoking and not using a smoking apron.</p> <p>The facility provided a list of residents who were approved current smokers on 6/22/26, R10's name was not included on the list.</p> <p>During an observation on 6/22/26 at 12:46 p.m., R10's clothing appeared soiled with white spots on shirt and pants and small holes in shirt (across abdomen) and in his pants in the thigh area.</p> <p>During an interview on 6/22/26 at 12:54 R10 stated he smoked independently.</p> <p>During an observation on 6/23/26 at 2:21 p.m., R10 was seated in his wheelchair in his room, he was wearing clean clothes. Both the shirt and pants had several small holes.</p> <p>During an observation on 6/24/26 at 2:09 p.m., R10 was headed outside, he had a pack of cigarettes in his breast pocket. His clothing was clean but had small holes in the shirt and pants. He declined to have anyone accompany him to the smoking area.</p> |                                                                  |  | F0689                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| F0689<br>SS = D                                                                  | <p>Continued from page 16</p> <p>During an observation on 6/24/26 at 2:17 p.m., there were food crumbs on the floor under the overbed table where R10 ate in his room.</p> <p>During an interview on 6/24/26 at 2:18 p.m., nursing assistant (NA)-A verified there were crumbs on the floor and what he stated looked like spilled milk on the overbed table. NA-A stated they had to wait for him to leave the room as he would not let them clean up after each meal.</p> <p>During an interview on 6/24/26 at 2:26 p.m., licensed practical nurse (LPN)-A verified there were food crumbs on the floor and the overbed table was wet from a beverage that had been spilled. LPN-A stated he would sometimes use adaptive eating utensils but would also eat using his hands. LPN-A stated he would not use the cigarette holder and stated the wounds on his hands were from burns from smoking. LPN-A verified the holes in his clothing were from burn holes from cigarette smoking but stated he would say they were not.</p> <p>During an interview on 6/24/26 at 2:28 p.m., registered nurse (RN)-A stated she had tried different options to have R10 hold a cigarette (related to his lack of fine motor coordination), but he was not receptive. RN-A verified R10's care plan identified he needed to use a cigarette holder to smoke. RN-A verified the holes in his clothing were from burn holes from cigarette smoking.</p> <p>During an interview on 6/26/26 at 8:04 a.m., the director of nursing (DON) verified R10 would not use a smoking apron and that RN-A and now occupational therapy were working with him for a safe option to hold a cigarette (related to his lack of fine motor coordination and safety with smoking).</p> <p>Smoking Policy – Residents dated 3/2/26, identified the facility would establish and maintain safe resident smoking practices. A resident's ability to smoke safely would be evaluated upon admission/readmission, quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) would be noted in the care plan, and all personnel caring for the resident would be alerted to these issues.</p> |                                                                  |  | F0689                                                                                        |                                                                                                                                                                                                                                                          |                                              | 08/07/2026                 |
| F0880<br>SS = D                                                                  | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |  | F0880                                                                                        | Enhanced Barrier Precautions (EBP) for Resident #103 were immediately reviewed. Appropriate EBP signage and required personal protective equipment (PPE) were implemented or corrected as indicated, and staff caring for the residents were immediately |                                              | 08/07/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |                            |
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| F0880<br>SS = D                                                                  | <p>Continued from page 17</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or</p> <p>infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> |                                                                  |  | F0880                                                                                        | <p>Continued from page 17</p> <p>in-serviced on the residents' required transmission-based precautions and proper use of PPE. An audit of all residents requiring Enhanced Barrier Precautions was conducted to verify that appropriate precaution signage, PPE availability, and EBP protocols were in place and being followed. Any deficiencies identified during the audit were corrected immediately.</p> <p>Licensed nurses, certified nursing assistants, and other direct care staff received re-education on the facility's Infection Prevention and Control Program, including Enhanced Barrier Precautions, appropriate PPE selection and use, hand hygiene, and adherence to CDC guidance and facility policy.</p> <p>The Infection Preventionist is responsible for compliance.</p> <p>Audits on PPE usage during high contact care activity will begin weekly for four weeks, followed by monthly audits for two months, to verify compliance with EBP requirements. Audit results will be reviewed through the Quality Assurance and Performance Improvement (QAPI) program, and corrective actions will be implemented for any identified noncompliance.</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                          |                                              |                            |
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| F0880<br>SS = D                                                                  | <p>Continued from page 18</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review, the facility failed to ensure Enhanced Barrier Precautions (EBP) protocols were followed for 1 of 1 resident (R103) reviewed for infection control.</p> <p>Findings include:</p> <p>R103's quarterly Minimum Data Set (MDS) dated 6/16/26, identified R103 was cognitively intact.</p> <p>R103's diagnoses included diabetes mellitus, renal insufficiency, neurogenic bladder, hypertension, anemia, arthritis, anxiety, and depression.</p> <p>R103's care plan dated 6/17/26, identified the resident was on EBP related to a suprapubic (SP) catheter and chronic wounds, and directed care staff to follow EBP and to utilize gowns and gloves for all personal care.</p> <p>R103's provider orders dated 12/11/25, included SP catheter cleansing and maintenance for neuromuscular dysfunction of bladder.</p> <p>During an observation on 6/24/26 at 12:58 p.m., R103's door had a sign indicating R103 was on EBP. The sign instructed staff to wear a gown and gloves for high-contact resident care activities, including dressing and transferring. Nursing assistant (NA)-C was observed in R103's room, without wearing a gown, squatting at R103's feet at bedside.</p> <p>During an interview on 6/24/26 at 1:33 p.m., NA-C</p> |                                                                  |  | F0880                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| F0880<br>SS = D                                                                  | <p>Continued from page 19</p> <p>confirmed they had not gowned when entering R103's room. NA-C stated they prepared R103 for an appointment, assisted with dressing, and transferred R103 from bed to wheelchair. NA-C stated they were squatting at bedside to put R103's compression socks on. NA-C stated they only needed to gown for EBP if taking care of an open wound. NA-C reviewed the EBP sign on R103's door and stated even though the sign indicated to wear a gown with dressing, they did not need to gown since they were not in contact with R103's wound. NA-C stated gowning for EBP was important to prevent transferring an infection to staff or other residents.</p> <p>During an interview on 6/24/26 at 3:01 p.m., registered nurse (RN)-C stated staff wear gown and gloves when providing cares to residents on EBP. RN-C expected staff to wear gown and gloves when assisting R103 with getting dressed and stated a concern for spreading infection if EBP was not followed.</p> <p>During an interview on 6/26/26 at 8:25 a.m., director of nursing (DON) stated staff were expected to read the EBP sign when entering a resident's room and apply the appropriate personal protective equipment (PPE). DON confirmed that staff needed to wear gown and gloves when assisting with dressing a resident on EBP and stated a concern for cross contamination of infection to staff if a gown was not worn.</p> <p>Facility provided Enhanced Barrier Precautions sign received 6/26/26, instructed providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and wound care.</p> |                                                                     |  | F0880                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              | 08/07/2026                 |
| F0921<br>SS = D                                                                  | <p>Safe/Functional/Sanitary/Comfortable Environ</p> <p>CFR(s): 483.90(i)</p> <p>§483.90(i) Other Environmental Conditions</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to ensure residents did not have to share a living space with a resident (R72)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                     |  | F0921                                                                                        | <p>R72 had a room change notice issued on 7/21/2026. R52 and R65 met with social service and a grievance form was completed. All current residents were reviewed for roommate compatibility and room changes were made as needed. Future resident placement, the existing resident will be given consent to choice per facility policy.</p> <p>The IDT team was in-serviced on the Resident Self Determination and Participation policy with emphasis on item #3a which explains that residents are encouraged to make choices regarding rooming with the person of his or her own choice, providing both individuals with consent to the choice.</p> |                                              | 08/07/2026                 |



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| F0921<br>SS = D                                                                  | <p>Continued from page 20<br/>who would not shower or change clothing. This deficient practice affected 3 of 3 residents (R52, R65, R44) reviewed for environment.</p> <p>Findings include:</p> <p>R72's quarterly Minimum Data Set (MDS) dated 5/14/26, identified he had diagnoses which included anemia, heart disease, hypertension, arthritis, depression, panlobular emphysema (an irreversible type of chronic obstructive pulmonary disease [progressive, incurable lung disease that blocks airflow and makes breathing difficult]), hypomagnesemia (a low level of magnesium in the blood), cannabis use, and gastroesophageal reflux disease (when stomach acid flows back up into the esophagus and causes heartburn). In addition, R72's MDS identified he was cognitively intact, had no rejections of care and was independent with activities of daily living (ADLS) including personal hygiene.</p> <p>R72's Medication Review Report dated 6/26/26, identified he had an order for a weekly bath audit on shower day every evening shift on Tuesdays.</p> <p>R72's care plan dated 2/4/26, identified R72 had a risk for self-care deficit related to bathing and dressing. Interventions included to evaluate his ability to perform ADLS, to maintain a consistent schedule, minimize environmental stimuli, to provide assistance with ADLs as needed, and to complete a risk versus benefit for bathing refusals.</p> <p>A review of R72's Weekly Bath Audits from January 2026 through June 2026, identified he had refused bath/showers every week for the past six months.</p> <p>A review of risk versus benefit on refusing showers and skin checks dated 2/4/26, identified two staff signed the document but there was no signature for R72.</p> <p>R72's provider notes identified the following:</p> <p>-12/26/25, identified he was declining any help with personal hygiene. "He is illkept, matted hair."</p> <p>-1/30/26, identified he declined any help with showers. "He is illkept, matted hair."</p> <p>-2/11/26, "Refuses any bathing or hygiene care frequently and appears disheveled. Not interested in decreasing ETOH (alcohol), tobacco, or marijuana at this time." "is in bed still at 11:00 today and disheveled appearing."</p> |                                                                  |  | F0921                                                                                        | <p>Continued from page 20<br/>Social Service Director is responsible for compliance.</p> <p>Audits on room change requests and resident consent to roommates will begin weekly x 2 weeks then monthly to ensure sustained compliance.</p> <p>Audit results will be reviewed through the Quality Assurance and Performance Improvement (QAPI) program, and corrective actions will be implemented for any identified noncompliance.</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| F0921<br>SS = D                                                                  | <p>Continued from page 21</p> <p>-5/15/26, "Refuses any bathing or hygiene care frequently and is quite disheveled." "Disheveled and unkempt."</p> <p>R52's comprehensive MDS dated 6/18/26, identified R52 was moderately cognitively intact.</p> <p>During an interview on 6/24/26 at 11:38 a.m., R52 stated he shared a room with R72 and didn't want to be in the same room with him. R52 stated that he coughed "all the time". R52 stated sometimes the bathroom would be dirty (the toilet) but he didn't have to clean it up staff would. R52 stated he had asked for a different room about five times.</p> <p>R65's quarterly MDS dated 6/25/26, identified R65 was cognitively intact.</p> <p>During an interview on 6/24/26 at 10:46 a.m., R65 stated he shared a bathroom with R72 and sometimes there would be "poop" on the toilet. R65 stated when that happened, he would tell nursing and they would come and clean it up.</p> <p>R44's quarterly MDS dated 6/18/26, identified R44 was cognitively intact.</p> <p>During an interview on 6/25/26 at 1:18 p.m. R44 stated sometimes the shared bathroom would be dirty with stool on the toilet, but he would tell nursing and they would clean it up.</p> <p>During the course of the survey 6/22/26-6/26/26, a staff member who wished to remain anonymous reported R72 had not showered in over a year, didn't change his clothing, didn't wash his hair (stated his hair was matted), and shared a bathroom with three other residents. The anonymous staff member stated the resident drank alcohol and "messes his pants", they stated the other three residents would complain about the bathroom being dirty.</p> <p>During an interview on 6/25/26 at 11:42 a.m., housekeeper (H)-A stated R72's room was "odorous" and R72's use of alcohol made it hard to keep the room and bathroom clean. H-A stated R72 didn't always make it to the bathroom in time when he needed to use it. H-A stated sometimes there would be stool on the floor, walls, toilet, and on his bed linen. H-A stated they believed he had not bathed, washed his hair, or changed his clothes for eight months. H-A stated housekeeping would use a deodorant spray when he was out of his room, check his bed to see if his bed linen needed to be</p> |                                                                  |  | F0921                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                          |                                              |                            |
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| F0921<br>SS = D                                                                  | <p>Continued from page 22</p> <p>changed (said it was often stained with stool) and would alert nursing to change the bed linens. H-A stated bed linens were typically changed on shower days but R72 would refuse his shower. H-A stated R52 has told her in the past that nothing happens if he complained about the room and the bathroom. H-A stated R65 has also complained to her about how dirty the bathroom would be after R72 used it. H-A stated the bathroom accidents usually occurred overnight, and she would find dried stool in the bathroom when she arrived in the morning about three times a week. H-A stated R52 and R65 would use the main bathroom/shower room when the bathroom would get too bad.</p> <p>During an interview on 6/25/26 at 12:00 p.m., nursing assistant (NA)-B stated she was aware of R72 refusing to shower and stated she didn't think he changed his clothes daily.</p> <p>During an interview on 6/25/26 at 12:04 p.m., licensed practical nurse (LPN)-B stated he was aware R72 refused to shower. LPN-B verified R52, R65, and R44 would come out and tell nursing staff when the bathroom was dirty and stated in fact R65 had told him that morning that the toilet seat had stool on it. LPN-B verified the room could be odorous.</p> <p>During an interview on 6/25/26 at 12:08 p.m., registered nurse (RN)-B stated R72 had not showered for the past six months, "maybe longer". RN-B stated he was somehow able to obtain alcohol, and wouldn't change his clothes or wash his hair. RN-B stated she was not aware that R52, R65, and R44 would sometimes use the shower room bathroom because the shared bathroom was so dirty. RN-B verified a reasonable person would not want to share a room or a bathroom with someone who refused to shower or change their clothing.</p> <p>During an interview on 6/26/26 at 7:58 a.m., the director of nursing (DON) stated it had been a "very, very, long time" since R72 had showered. The DON verified she has had to clean the shared bathroom of stool. The DON verified a reasonable person would not want to share a room or a bathroom with someone who refused to shower or change their clothes.</p> <p>Weekly Skin Care Policy and Procedure dated 4/10/26, "Residents will have weekly scheduled showers/baths." The policy identified skin care would enhance the quality of life for all residents residing in the facility. The policy did not address</p> |                                                                  |  | F0921                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245227 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X3) DATE SURVEY COMPLETED<br><br>06/26/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                              |                            |
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| F0921<br>SS = D                                                                  | Continued from page 23<br>refusals to bathe or shower.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  | F0921                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                              | 08/07/2026                 |
| F0576<br>SS = B                                                                  | <p>Right to Forms of Communication w/ Privacy</p> <p>CFR(s): 483.10(g)(6)-(9)</p> <p>§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.</p> <p>§483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:</p> <p>(i) A telephone, including TTY and TDD services;</p> <p>(ii) The internet, to the extent available to the facility; and</p> <p>(iii) Stationery, postage, writing implements and the ability to send mail.</p> <p>§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:</p> <p>(i) Privacy of such communications consistent with this section; and</p> <p>(ii) Access to stationery, postage, and writing implements at the resident's own expense.</p> <p>§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.</p> <p>(i) If the access is available to the facility</p> <p>(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.</p> <p>(iii) Such use must comply with State and Federal law.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> |                                                                  |  | F0576                                                                                        | <p>Facility Social Service designee met with R101and R85 and filled out a global grievance regarding absence of mail delivery on weekend. Grievance will be completed and resolution recorded and resident satisfaction of resolution recorded. Current and future residents will have mail delivered per facility policy.</p> <p>Facility staff and Activity Director will be in-serviced on the Mail/Electronic Communication policy and procedure with emphasis on Mail and packages will be delivered to the residents within twenty-four (24) hours of delivery on premises (including Saturday deliveries). Saturday mail will be delivered by the facility charge nurse. Saturday mail will be delivered on the same day to residents when the mail is delivered to the facility.</p> <p>The Activity Director is responsible for compliance.</p> <p>Audits on mail delivery date to facility, was mail delivered to the resident within 24hrs of arrival to the facility and if mail was received by facility resident on Saturday will begin weekly x 4 weeks, then monthly to ensure sustained compliance.</p> <p>Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation.</p> <p>Compliance: August 7, 2026</p> |                                              | 08/07/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                          |                                              |                            |
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| F0576<br>SS = B                                                                  | <p>Continued from page 24</p> <p>Based on interview and document review, the facility failed to ensure that mail was delivered to residents on Saturdays. This had the ability to affect all residents who received mail to the facility.</p> <p>Findings include: R101's annual Minimum Data Set (MDS) dated, 5/21/26, identified R101 as cognitively intact. R85's annual MDS dated 4/2/26, identified R85 as cognitively intact. During interview on 6/25/26 at 9:57 a.m., R101 stated that if mail comes on Saturday, it is not being delivered until Monday. R85 confirmed that mail gets delivered to the front desk on Saturday and is sorted and delivered on Monday. During interview on 6/25/26 10:54 a.m., the front desk receptionist and business office manager (BOM)-A stated they deliver to residents during the week. On Saturday if they are expecting something for mail, they can come and grab it, otherwise we go though it on Monday and deliver it out through the facility. Facility policy, Mail and Electronic Communication, undated, indicated mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries).</p> |                                                                     |  | F0576                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



Minnesota Department of Health

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| 20000                                                                            | <div>Initial Comments</div> <div>*****ATTENTION*****</div> <div>NH LICENSING CORRECTION ORDER</div> <div>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</div> <div>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</div> <div>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</div> <div>INITIAL COMMENTS:</div> <div>On 6/22/26-6/26/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.</div> <div>The following complaints were reviewed: H52273099C (3006525). NO licensing orders were</div> |                                                                 |  | 20000                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| 20000                                                                            | <p>Continued from page 1 issued.</p> <p>The following complaints were reviewed:<br/>H52273100C (3022363). NO licensing orders were issued.</p> <p>The following complaints were reviewed:<br/>H52272793C (3035178). NO licensing orders were issued.</p> <p>The following complaints were reviewed:<br/>H52272819C (3035998). NO licensing orders were issued.</p> <p>The following complaints were reviewed:<br/>H52273101C (1099878). with a licensing order issued at 20960.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin<br/><a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO</p> |                                                                 |  | 20000                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| 20000                                                                            | Continued from page 2<br>FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR<br>ON EACH PAGE. THERE IS NO REQUIREMENT TO<br>SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS<br>OF MINNESOTA STATE STATUTES/RULES.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                 |  | 20000                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |
| 20920                                                                            | <p>Rehab - ADLs</p> <p>CFR(s): MN Rule 4658.0525 Subp. 6 B</p> <p>Subp. 6. Activities of daily living. Based on the<br/>comprehensive resident assessment, a nursing home<br/>must ensure that:</p> <p>B. a resident who is unable to carry out activities of<br/>daily living receives the necessary services to<br/>maintain good nutrition, grooming, and personal and<br/>oral hygiene.</p> <p>This LICENSURE REQUIREMENT is NOT MET as<br/>evidenced by:</p> <p>Based on observation, interview, and record review<br/>the facilty failed to honor shaving preferences and<br/>needed assistance for 1 of 1 residents (R112) who<br/>required minimal assistance with shaving and oral<br/>care.</p> <p>Findings include:R112's admission Minimum Data<br/>Set (MDS) dated 6/22/26, status: ready for export,<br/>indicated R112 was cognitively intact with the<br/>diagnoses of encounter for orthopedic after care,<br/>kidney disease, diabetes, congestive heart failure<br/>and muscle weakness. Section GG indicated R112<br/>required setup or clean-up assistance for personal<br/>hygiene including shaving and oral hygiene.</p> <p>R112's care plan last updated dated 6/23/26, did<br/>not include R112's general preferences or activities<br/>of living (ADL) preferences. The Focus area<br/>Functional Discharge Goals included: hygiene goal:<br/>set up or clean up assistance with personal hygiene.<br/>The oral hygiene goal identified was to be<br/>independent with oral hygiene.</p> <p>On 6/22/26 at 2:04 p.m., R112 stated staff had not<br/>offered to help them get set up to brush their teeth,<br/>they had to ask them to help, or it wouldn't get<br/>done. R112 touched their face and said they hadn't<br/>been able to shave since they got to the facility.<br/>They had asked multiple staff but so far nobody had<br/>helped them. R112 explained at home they only kept<br/>a goatee, and they didn't want all the new whiskers<br/>as they were itchy. R112 wanted to be cleaned<br/>shaved just like they were at home. It was noted<br/>R112 had significant whisker stubble on their face<br/>and under their chin.</p> |                                                                 |  | 20920                                                                                        | Corrected                                                                                                                |                                              | 08/07/2026                 |



Minnesota Department of Health

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| 20920                                                                            | <p>Continued from page 3</p> <p>During an interview on 6/24/26 at 9:09 a.m., R112 was noted to have significant whisker growth on the face and neck outside of their goatee. R112 stated they had not been able to shave yet, they had now been waiting three days for help. R112 stated they had asked for help once today, three times yesterday, and multiple times the day before that. R112 thought they had asked at least three or four different staff for assistance. Today, staff had said they were working on it, but nothing had happened yet.</p> <p>During an interview on 6/24/26 at 1:19 p.m., nursing assistant (NA-A) stated the facility had disposable razors that could be used to shave a resident if they didn't have their own shaver or razors. NA-A stated if a resident asked to be shaved staff should do it.</p> <p>During an interview on 6/24/26 at 1:45 p.m., registered nurse manager (RN-D) stated resident preferences were looked at during admission by the charge nurse. In addition, RN-D indicated they and the social worker did a meet and greet with the resident and reviewed their preferences which included shaving and oral care. RN-D stated they would expect shaving to get done when a resident asked.</p> <p>During an interview on 6/25/26 at 9:20 a.m., NA-D stated as NA's they did shave residents. We ask residents if they want to be shaved and then we do it if that is what they wanted. Stock supply razors would be used if a resident did not have their own razor or shaver.</p> <p>During an interview on 6/25/26 at 9:23 a.m., R112 continued to have whisker growth on their face and neck. R112 stated staff had not offered to assist them with brushing their teeth or with getting shaved yesterday or today even after they had asked to shave yesterday. They really needed to shave because they were sick of their face constantly being itchy.</p> <p>During an interview on 6/25/26 at 2:12 p.m., RN-D, stated staff should be setting up and offering assistance with ADLs to residents who have triggered for some level of assistance on the MDS.</p> <p>During an interview on 6/25/26 at 3:03 p.m., the director of nursing (DON) stated when a resident requested to shave, they expected staff to assist the resident to shave as soon as able the same day. They also expected staff to go in and offer assistance and or set up residents so they could</p> |                                                                 |  | 20920                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



Minnesota Department of Health

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| 20920                                                                            | <p>Continued from page 4<br/>shave/brush their teeth themselves. If residents were not doing those things for themselves, the DON expected staff to complete those cares without having to be asked by residents.</p> <p>The facility policy Activities of Daily Living (ADLs), Supporting dated 6/25/26, instructed residents will be provided with care, treatment and services as appropriate, to maintain or improve their ability to carry out activities of daily living. Services identified included bathing, dressing, grooming, and oral care.</p> <p>The facility policy Resident Rights dated 7/14/21, identified that residents had the right to self-determination.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents requiring assistance with ADLs and educate staff to cares. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented to provide necessary ADLs. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> |                                                                 | 20920               |                                                                                                                          |  | 08/07/2026                                   |  |
| 20960                                                                            | <p>Dietary Service - Food Quality</p> <p>CFR(s): MN Rule 4658.0600 Subp. 1</p> <p>Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to ensure meals were palatable for 8 of 14 residents (R17, R12, R10, R4, R5, R58, R61, R81) who expressed dissatisfaction with palatability of meals. In addition, the facility failed to ensure the temperature of foods was maintained when transported to resident rooms.</p> <p>Findings include:</p> <p>R17's quarterly Minimum Data Set (MDS) dated</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 | 20960               | Corrected                                                                                                                |  | 08/07/2026                                   |  |



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| 20960                                                                            | <p>Continued from page 5</p> <p>6/11/26, identified R17 was moderately cognitively intact.</p> <p>During an interview on 6/22/26 at 2:30 p.m., R17 stated the food was “pretty much terrible”.</p> <p>During an observation on 6/24/26 at 1:02 p.m., R17 was no longer in the main dining room. He had eaten only a few bites of the meal which was a French dip sandwich, French fries, and a creamy cucumber salad.</p> <p>R12’s quarterly MDS dated 6/1/26, identified R12 was cognitively intact.</p> <p>During an interview on 6/22/26 at 3:15 p.m., R12 stated the food was poor quality, said the cooks didn’t know how to cook, and went on to state the hot food was not hot, and ice cream was served melted. R12 stated they were also not able to get oil and vinegar for a salad.</p> <p>During an observation and interview on 6/23/26 at 12:55 R12 stated she had not received any dressing for the salad. The meal was nacho chicken, shredded lettuce and tomato, refried beans, corn, and frosted marble cake.</p> <p>R10’s quarterly MDS dated 5/29/26, identified R10 was cognitively intact.</p> <p>During an interview on 6/22/26 at 12:45 p.m., R10 stated the eggs were served cold and overcooked. R10 stated there was no variety and no seasoning.</p> <p>During an observation and interview on 6/23/26 at 12:59 p.m., R10 had a lunch of chicken breast, corn, refried beans, he touched his food and stated it was cold.</p> <p>R4’s quarterly MDS dated 6/4/26, identified R4 was cognitively intact.</p> <p>During an interview on 6/22/26 at 5:33 p.m., R4 stated the food had gone “downhill”, the hot food was not hot, and the cold food was not cold.</p> <p>R5’s quarterly MDS dated 3/31/26, identified R5 was cognitively intact.</p> <p>During an interview on 6/22/26 at 3:00 p.m., R5 stated that lots of the food was “bad”.</p> <p>R81’s quarterly MDS dated 6/11/26, identified R81 was cognitively intact.</p> |                                                                 |  | 20960                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| 20960                                                                            | <p>Continued from page 6</p> <p>During an interview on 6/22/26 at 1:11 p.m., R81 stated the food was “awful”, no taste for the potatoes, the chicken was dry and in general the food was overcooked.</p> <p>During an observation and interview on 6/23/26 at 1:00 p.m., R81 stated his food was “awful”, staff had removed it to reheat it.</p> <p>During an observation on 6/23/26 at 12:20 p.m., a speed cart arrived with a plastic covering. The entrees were covered as were the beverages.</p> <p>At 12:27 p.m., staff added coffee to cups and placed them on the meal trays</p> <p>At 12:30 p.m., staff began passing out the meal trays to the residents who were eating in their rooms</p> <p>At 12:41 p.m., a second tray arrived on another hallway with a plastic covering, staff performed hand hygiene and began passing out the meal trays to resident who were eating in their rooms</p> <p>During an interview on 6/26/26 at 8:15 a.m., the director of nursing (DON) stated they were aware of the food complaints since February.</p> <p>R58’s quarterly Minimum Data Set (MDS) dated 4/16/26, identified R58 was cognitively intact.</p> <p>R61’s quarterly MDS dated 3/26/26, identified R61 was cognitively intact.</p> <p>During an observation on 6/24/26 at 12:44 p.m., lunch trays were being delivered to resident rooms from an open ladder rack with plates in insulated serving dishes and milk cartons on the tray. The culinary director (CD) took temperatures on the last room tray served. The roast beef on a bun was 100.4 degrees Fahrenheit (F), the cup of au jus was 106.5 degrees F, and the carton of milk was 54.3 degrees F.</p> <p>During an interview on 6/24/26 at 12:44 p.m., CD confirmed the temperatures of foods on the last tray served were not what they expected for food quality. They stated their main concern was related to quality and palatability, and indicated safety would be a concern if it had been greater than 2 hours.</p> <p>During resident council interview on 6/25/26 at 9:57 a.m., R58 and R61 indicated the food concerns had not been fully addressed. They stated food quality and temperature were not great, food was always</p> |                                                                 |  | 20960                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



Minnesota Department of Health

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| 20960                                                                            | <p>Continued from page 7</p> <p>cold when eating in their room, and cold food was not always reheated by staff when requested.</p> <p>During an interview on 6/25/26 at 10:33 a.m., activity director (AD), indicated they were aware of the cold food concerns. They brought all food concerns to Quality Assurance and Performance Improvement (QAPI) and the food department manager.</p> <p>During an interview on 6/26/26 at 8:45 a.m., the director of nursing (DON) stated they expected trays delivered to resident rooms were hot, and cold items cold. They had concerns about food quality.</p> <p>Review of Resident Council meeting minutes:</p> <p>Resident Council Meeting minutes dated 2/12/26 at 10:00 a.m., with 18 residents attending, indicated concerns about cold food and needing staff to reheat the food.</p> <p>Resident Council Meeting minutes dated 4/9/26 at 10:00 a.m., with 15 residents attending, indicated residents were asked for any concerns, compliments, or suggestions for dietary.</p> <p>Resident Council Meeting minutes dated 6/11/26 at 10:00 a.m., with 22 residents attending, indicated concerns about food quality including food being overcooked and rubbery.</p> <p>Food Temperatures policy dated 2026, instructed that foods sent to the units for distribution will be transported and delivered to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee should ensure food served is attractive and palatable to residents. The facility should update/create policies and procedures regarding the importance of food appearance and taste, and educate staff on these changes. The administrator or designee should perform measurable audits for a specific of time, determined by QAPI, to ensure food served has been approved by the facility's registered or licensed dietician and served to residents. The facility should report audit findings to QAPI for further recommendations to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> |                                                                 |  | 20960                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| 21015                                                                            | <p>Dietary Staff Requirements- Sanitary conditi</p> <p>CFR(s): MN Rule 4658.0610 Subp. 7</p> <p>Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to consistently track and monitor dishwasher temperatures for both the wash and rinse cycles, and take timely action to correct the temperatures, for 1 of 1 dishwasher. This had the potential to affect all current residents, as well as staff or visitors, who ate food served from dishes and tableware that were cleaned in the dishwasher. Additionally, the facility failed to ensure proper sanitary storage of cleaning products and personal protective equipment and failed to ensure staff appropriately covered facial hair</p> <p>Findings include:</p> <p>Dishwasher temperatures:</p> <p>During an observation on 6/25/26 at 9:38 a.m., dietary aide (DA)-A was operating the dirty side of the dishwasher and DA-B was removing dishes on the clean side of the dishwasher. DA-A completed a wash cycle. On the dishwasher, the rinse temperature was observed to be 180 degrees Fahrenheit (F), and the wash temperature gauge was not functioning.</p> <p>During an interview on 6/25/26 at 10:11 a.m., DA-A stated dishwasher temperatures were logged by staff working the clean side of the dishwasher every shift. DA-A started a wash cycle, observed the temperature gauges, and confirmed the wash temperature gauge was not functioning. DA-A stated this was not good because the wash temperature was not known.</p> <p>During an observation on 6/25/26 at 10:15 a.m., dishwashing logs for May 2026 and June 2026 were reviewed and included columns labeled wash and rinse for each meal. The June 2026 dishwashing temperature log had no temps logged for all meals 15 out of 25 days, no temps were logged for dinner, and all recorded breakfast rinse temps were logged below 180 degrees F, ranging from 170-175 degrees F, with no follow-up notations. The May 2026 dishwashing temperature log had no temps logged for all meals 23 out of 31 days and no temps were</p> |                                                                 |  | 21015                                                                                        | Corrected                                                                                                                |                                              | 08/07/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                          |                                              |                            |
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| 21015                                                                            | <p>Continued from page 9<br/>logged for dinner.</p> <p>During an interview on 6/25/26 at 10:17 a.m., cook (C)-A reviewed the dishwasher temperature logs for May 2026 and June 2026. C-A confirmed that temperatures were not logged consistently, and several recorded rinse temperatures were below 180 degrees F and was concerned that dishes were not heated for proper sanitation.</p> <p>During an interview on 6/25/26 at 10:19 a.m., DA-B stated dishwasher temperatures were logged every shift. DA-B confirmed they had not logged the morning temperatures and stated they were running late that morning.</p> <p>During an interview on 6/25/26 at 10:29 a.m., culinary director (CD) observed the dishwasher running and confirmed the wash temperature gauge was not moving and the rinse temperature was 175 degrees F. CD asked DA-B about the wash gauge and DA-B stated, "sometimes it works, sometimes it doesn't." CD was concerned that if the dishwasher was not reaching appropriate temperatures, it may not be killing germs. CD stated they expected staff to log temperatures twice daily and let them know if there were issues. CD stated the dishwasher was leased from Ecolab, they needed to call for service, and asked staff to use the 3-compartment sink until it was resolved.</p> <p>During an interview on 6/25/26 at 12:55 p.m., Ecolab technician identified the dishwasher as a high-temperature dishwasher and confirmed the wash temperature gauge had failed. They stated the minimum wash temperature for the machine was 160 degrees F and the minimum rinse temperature was 180 degrees F. They identified during their service call on 6/25/26, a T60 test strip applied to a ceramic plate during dishwasher run had turned black which verified the dish reached 160 degrees F and was sanitized.</p> <p>The dishwasher temperature gauges indicated wash temperature minimum was 160 degrees F and rinse temperature minimum was 180 degrees F.</p> <p>A copy of dishwashing logs for May 2026 and June 2026 were requested but not received.</p> <p>Cleaning Dishes Using a Dish Machine policy dated 2026, instructed that proper temperatures and machine function should be verified prior to use, and staff should check the dish machine gauges throughout the cycle to ensure proper temperatures for sanitation. It identified for a high-temperature</p> |                                                                 |  | 21015                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| 21015                                                                            | <p>Continued from page 10</p> <p>dishwasher that the wash cycle reaches 150 to 165 degrees F and the rinse cycle reach 180 degrees F.</p> <p>Ecolab manufacturer instructions dated 2020, identified the following water temperature requirements:</p> <p>Wash temperature (hot water sanitizing) 160°F</p> <p>Rinse temperature (hot water sanitizing) 180°F</p> <p>Sanitary Storage:</p> <p>During a kitchen observation on 6/25/26 at 9:45 a.m., a closet between the kitchen and the entrance to the dirty side of the dishwasher was observed to be open and disorganized with open chemical containers, open boxes of gloves, and more than a dozen flies swarming and landing on the closet contents.</p> <p>During an interview on 6/25/26 at 10:36 a.m., CD observed the closet and stated they had not seen the closet before as they were new to the facility. CD identified the open chemicals as partially full Ecolab Solitaire dish detergent. CD stated they expected the closet to be closed, organized, and the chemical containers covered. CD had concerns for contamination from the flies.</p> <p>Chemical storage policy, personal protective equipment storage policy, and pet control policy were requested but not received.</p> <p>Facial Hair:</p> <p>During a kitchen observation on 6/25/26 at 11:50 a.m., other kitchen staff (O)-D was placing fruit and dessert cups on resident trays on a ladder rack. O-D was observed to have a full beard and mustache that were not covered with a facial hair net.</p> <p>During an interview on 6/25/26 at 11:50 a.m., O-D stated hairnets are required for facial hair, confirmed they should have a hairnet covering their beard, and stated the concern was for hair falling into the food.</p> <p>During an interview on 6/25/26 at 12:37 p.m., CD stated hair nets are required if facial hair was long enough to grab. CD was concerned for hair falling into food and possibly carrying pathogens if facial hair was not covered while serving food.</p> <p>SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or</p> |                                                                 |  | 21015                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| 21015                                                                            | Continued from page 11<br>administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 | 21015               |                                                                                                                          |  | 08/07/2026                                   |  |
| 21385                                                                            | Infection Control; Staff assistance<br><br>CFR(s): MN Rule 4658.0800 Subp. 3<br><br>Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review, the facility failed to ensure Enhanced Barrier Precautions (EBP) protocols were followed for 1 of 1 resident (R103) reviewed for infection control.<br><br>Findings include:<br><br>R103's quarterly Minimum Data Set (MDS) dated 6/16/26, identified R103 was cognitively intact.<br><br>R103's diagnoses included diabetes mellitus, renal insufficiency, neurogenic bladder, hypertension, anemia, arthritis, anxiety, and depression.<br><br>R103's care plan dated 6/17/26, identified the resident was on EBP related to a suprapubic (SP) catheter and chronic wounds, and directed care staff to follow EBP and to utilize gowns and gloves for all personal care.<br><br>R103's provider orders dated 12/11/25, included SP catheter cleansing and maintenance for neuromuscular dysfunction of bladder.<br><br>During an observation on 6/24/26 at 12:58 p.m., |                                                                 | 21385               | Corrected                                                                                                                |  | 08/07/2026                                   |  |



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| 21385                                                                            | <p>Continued from page 12</p> <p>R103's door had a sign indicating R103 was on EBP. The sign instructed staff to wear a gown and gloves for high-contact resident care activities, including dressing and transferring. Nursing assistant (NA)-C was observed in R103's room, without wearing a gown, squatting at R103's feet at bedside.</p> <p>During an interview on 6/24/26 at 1:33 p.m., NA-C confirmed they had not gowned when entering R103's room. NA-C stated they prepared R103 for an appointment, assisted with dressing, and transferred R103 from bed to wheelchair. NA-C stated they were squatting at bedside to put R103's compression socks on. NA-C stated they only needed to gown for EBP if taking care of an open wound. NA-C reviewed the EBP sign on R103's door and stated even though the sign indicated to wear a gown with dressing, they did not need to gown since they were not in contact with R103's wound. NA-C stated gowning for EBP was important to prevent transferring an infection to staff or other residents.</p> <p>During an interview on 6/24/26 at 3:01 p.m., registered nurse (RN)-C stated staff wear gown and gloves when providing cares to residents on EBP. RN-C expected staff to wear gown and gloves when assisting R103 with getting dressed and stated a concern for spreading infection if EBP was not followed.</p> <p>During an interview on 6/26/26 at 8:25 a.m., director of nursing (DON) stated staff were expected to read the EBP sign when entering a resident's room and apply the appropriate personal protective equipment (PPE). DON confirmed that staff needed to wear gown and gloves when assisting with dressing a resident on EBP and stated a concern for cross contamination of infection to staff if a gown was not worn.</p> <p>Facility provided Enhanced Barrier Precautions sign received 6/26/26, instructed providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and wound care.</p> <p>SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding enhanced barrier precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and</p> |                                                                 |  | 21385                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| 21385                                                                            | Continued from page 13<br>re-education anytime enhanced barrier precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | 21385               |                                                                                                                          |  | 08/07/2026                                   |  |
| 21426                                                                            | Tuberculosis Prevention And Control<br><br>CFR(s): MN St. Statute 144A.04 Subd. 3<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis<br><br>infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review the facility failed to ensure two of two nursing agency staff (RN-E, LPN-C) had been screened and tested for tuberculosis (TB) according to the Minnesota Department of Health requirements prior to starting work at the facility. This deficient practice had the potential to impact all residents who resided at the facility.<br><br>Licensed practical nurse (LPN-C) was hired on 4/5/26. The facility records indicated LPN-C had had a negative IGRA test (Interferon-Gamma release assay test: a blood test that measures the body's response to TB antigens) on 1/7/21. A TB screening (screens for TB symptoms and TB testing history) |                                                                 | 21426               | Corrected                                                                                                                |  | 08/07/2026                                   |  |



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| 21426                                                                            | <p>Continued from page 14<br/>was not included in LPN-C's record.</p> <p>Registered nurse (RN-E) was hired on 5/15/26. The facility records indicated RN-E had had a negative IGRA test resulted on 10/23/24. A TB screening was not included in RN-E's records.</p> <p>During an interview on 6/25/26 at 9:40 a.m., human resources (HR-F) stated they communicated with the staff agency to get documentation for new agency staff. For TB the agency typically sent a chest x-ray or blood work testing. HR-F looked at the records to make sure TB testing had been done. Then they let the IP know they were getting a new staff. HR-F stated they did not look at the date of testing, or for a completed TB screening, it was more of the IP's thing to make sure the testing was good.</p> <p>During an interview on 6/25/26 at 11:35 a.m., the infection preventionist (IP) stated human resources (HR) obtained and maintained the documentation for new contracted agency staff. As the IP they did not routinely review agency staff TB documents as part of their process. They had thought human resources reviewed TB documentation for compliance once it was received from the staffing agency. Now that they were aware two agency staff did not have TB screening or current testing on record, they would be following up on how best to ensure screening and testing was current and on file before agency staff started at the facility. The IP stated new testing needed to be done and on record before an agency staff member started if it had been more than a year since their last TB testing had been done. The agency staff should have had screening and testing in place before they started at the facility.</p> <p>During an interview on 6/25/26 at 3:02 p.m., the director of nursing (DON) stated they expected all staff including agency staff to have required screening and testing for TB completed before they started working at the facility. It was expected that the staffing agency would make sure all the required TB testing and screening was current and completed before they sent a staff to work at the facility. It was unfortunate this had not happened for the two agency staff employees in question. The DON stated this would need to be addressed right away.</p> <p>The facility policy Tuberculosis, Employee Screening for TB dated 6/25/26, directed all newly hired employees would be screened for latent and active TB disease prior to the employee's duty assignment. The employee health coordinator or designee would accept documented TST or IGRA results within the proceeding 90 days. If no TST or IGRA results are</p> |                                                                 |  | 21426                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| 21426                                                                            | Continued from page 15<br>documented, an employee must have a skin test completed with a negative result prior to starting work.<br><br>SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                  |                                                                 | 21426               |                                                                                                                          |  | 08/07/2026                                   |  |
| 21565                                                                            | Administration of Medications Self Admin<br><br>CFR(s): MN Rule 4658.1325 Subp. 4<br><br>Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to ensure that a resident who was assessed to be unable to self-administer medications did not self-administer nebulizer treatments. This affected 1 of 1 resident (R8) reviewed for self-administration of medication.<br><br>Findings include: R8's quarterly Minimum Data Set (MDS) dated 4/22/26, identified R8 as cognitively intact. Diagnosis included chronic obstructive pulmonary disease (COPD) and rheumatoid arthritis (RA). R8's MDS further indicated that she was assessed as unable to self-administer medications. R8's current orders, reviewed 6/24/26, included Albuterol Sulfate Inhalation Nebulization Solution 2.5 milligrams (mg), inhale orally three times a day. Current orders failed to indicate R8 was able |                                                                 | 21565               | Corrected                                                                                                                |  | 08/07/2026                                   |  |



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| 21565                                                                            | <p>Continued from page 16</p> <p>to self-administer medications. During observation on 6/24/26 at 11:00 a.m., R8's nebulizer sat atop her bedside table with noted droplets in the nebulizer chamber. During interview on 6/24/26 at 11:47 a.m., R8 stated that she uses her nebulizer three times daily. Staff sets it up and I turn it on. They don't come back to clean it. During interview on 6/24/26 at 12:24 p.m., registered nurse (RN)-F stated that she can't say the last time she passed meds on R8's unit, but if they can self-administer medications it should show on the medication administration record (MAR) or in their orders. During interview on 6/24/26 at 1:12 p.m., trained medication aide (TMA)-A stated that she sets up R8's nebulizer, R8 completes the treatment, and she later goes back to clean the nebulizer. There are currently three people on this unit that can self-administer oral medications once set up, and R8 is not one of them. Residents usually have a separate order to self-administer nebulizers themselves. On 6/25/26 at 12:38 p.m., the director of nursing (DON) confirmed that R8 was assessed as unable to self-administer medications and there was not a current order for R8 to self-administer medications. The DON stated the expectation would be that a resident would have a SAM assessment indicating that they can self-administer an albuterol nebulizer. Facility policy, Self-Administration of Medications, undated, identified "If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluates options which allow residents to safely participate in the medication administration process if they wish to do so. "</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies for self-administration of medication according to evidence-based practices/procedures. Nursing staff should be educated as necessary to the importance of ensuring the resident is deemed capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff should also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, should audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee should take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.</p> |                                                                 |  | 21565                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| 21565                                                                            | Continued from page 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | 21565               |                                                                                                                          |  | 08/07/2026                                   |  |
| 21610                                                                            | <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> <p>Medicine Cabinet and Preparation Area;Storage</p> <p>CFR(s): MN Rule 4658.1340 Subp. 1</p> <p>Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to properly dispose of medications in the second-floor medication storage room. This had the ability to affect any resident who received medications from the second-floor medication storage room.</p> <p>Findings include: During a tour of the second-floor medication room with licensed practical nurse (LPN)-D on 6/25/26 at 9:23 a.m., multiple medications were observed to be expired. LPN-D stated that he wasn't sure of the process to remove the expired medications and I would have to follow up with director of nursing (DON). LPN-D stated that a lot of the medications in the medication storage room were overflow. Expired medications included the following: -saline nasal gel, expired 4/28/25-magnesium chloride, expired 4/9/26-docusate sodium, expired 12/4/25-cephalaxin, filled 9/16/25-Tylenol assigned to R19, expired 6/18/25. During an interview on 6/25/26 at 12:34 p.m., the director of nursing (DON) stated the nurse managers, or her audit medication carts monthly, but she had not audited the second-floor medication storage room. The expectation would be that nurses would put the expired medications in in the medication disposal bank on the first floor. Facility policy, Storage of Medications, undated, identified that discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling, storage, and disposal of medications and/or storage of items in the medication room or refrigerators. Nursing and/or medication aide staff should be educated to those changes. The DON or designee,</p> |                                                                 | 21610               | Corrected                                                                                                                |  | 08/07/2026                                   |  |



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| 21610                                                                            | Continued from page 18<br>and pharmacist, should routinely audit all<br>medications and storage to ensure compliance. The<br>results of those audits should be taken to QAPI<br>ongoing to determine compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21)<br>days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 | 21610               |                                                                                                                          |  | 08/07/2026                                   |  |
| 21825                                                                            | Patients & Residents of HC Fac.Bill of Rights<br><br>CFR(s): MN St. Statute 144.651 Subd. 9<br><br>Subd. 9. Information about treatment. Residents shall<br>be given by their physicians complete and current<br>information concerning their diagnosis, treatment,<br>alternatives, risks, and prognosis as required by the<br>physician's legal duty to disclose. This information<br>shall be in terms and language the residents can<br>reasonably be expected to understand. Residents<br>may be accompanied by a family member or other<br>chosen representative, or both. This information<br>shall include the likely medical or major<br>psychological results of the treatment and its<br>alternatives. In cases where it is medically<br>inadvisable, as documented by the attending<br>physician in a resident's medical record, the<br>information shall be given to the resident's guardian<br>or other person designated by the resident as a<br>representative. Individuals have the right to refuse<br>this information.<br><br>Every resident suffering from any form of breast<br>cancer shall be fully informed, prior to or at the time<br>of admission and during her stay, of all alternative<br>effective methods of treatment of which the treating<br>physician is knowledgeable, including surgical,<br>radiological, or chemotherapeutic treatments or<br>combinations of treatments and the risks associated<br>with each of those methods.<br><br>This LICENSURE REQUIREMENT is NOT MET as<br>evidenced by:<br><br>Based on interview and document review, the facility<br>failed to ensure residents were informed of and<br>consented to medications prescribed and given for<br>mental health intervention for 1 of 5 residents (R2)<br>reviewed for unnecessary medications.<br><br>Findings include:R2's quarterly Minimum Data Set<br>(MDS) dated 4/1/26, identified R2 was cognitively<br>intact.<br><br>R2's diagnoses included heart failure, renal<br>insufficiency, schizoaffective disorder, |                                                                 | 21825               | Corrected                                                                                                                |  | 08/07/2026                                   |  |



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| 21825                                                                            | <p>Continued from page 19<br/>non-Alzheimer's dementia, and arthritis.</p> <p>R2's care plan dated 6/26/26, identified R2 uses psychotropic medications related to behavior management. R2's provider orders dated 8/18/25, included mirtazapine oral tablet 15 mg: Give 15 mg by mouth at bedtime for depression. R2's provider orders dated 8/19/25, included risperidone oral tablet 0.5 mg: Give 1 tablet by mouth two times a day for mood disorder.</p> <p>R2's Informed Consent for Required Medications dated 2/5/24, for risperidone 2.5 mg two times a day for bipolar, was signed by R2.</p> <p>R2's medical record had no Informed Consent for Required Medications for mirtazapine.</p> <p>During interview on 6/26/26 at 9:06 a.m., director of nursing (DON) stated consents for psychotropic medications were obtained by a resident's physician, and nursing staff should ensure the consents were in the medical record. DON stated the physician should be updating the consents when prescribing new medications. DON confirmed R2 had no consent for mirtazapine in their medical record, and stated concern for lacking informed consent from R2.</p> <p>Antipsychotic Medication Use policy dated 4/26/2025, instructed that the resident record must include provider diagnosis, indication for use and documentation that the resident acknowledged consent to receive prescribed psychotropic medications.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee should develop and implement measures to ensure the physician or other practitioner or professional, informed the resident of the risks and benefits of treatment and treatment alternatives, and obtained resident consent for the treatment. The facility should update policies and procedures, educate staff on those changes, and perform measurable audits to ensure the needs of resident(s) are maintained. The facility should report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> |                                                                 |  | 21825                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                          |                                              |                            |
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| K0000<br>Bldg. 01                                                                | <p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/23/2026. At the time of this survey, Bayshore Residence &amp; Rehab Ctr was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required.</p> <p>Healthcare Fire Inspections</p> <p>State Fire Marshal Division</p> <p>445 Minnesota St., Suite 145</p> |                                                                  |  | K0000                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |

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 reverse for further 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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| K0000<br>Bldg. 01                                                                | <p>Continued from page 1<br/>St. Paul, MN 55101-5145, OR</p> <p>By email to:</p> <p>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <p>A detailed description of the corrective action taken or planned to correct the deficiency.</p> <p>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.</p> <p>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</p> <p>4. Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>5. The actual or proposed date for completion of the remedy.</p> <p>Bayshore Health Center is a 2-story building with no basement. The original building was constructed in 1969, with an addition in 1978. The original building and additions are all Type II (111) construction; therefore, the facility was inspected as one building.</p> <p>The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification.</p> <p>The facility has a capacity of 139 beds and had a census of 99 at the time of the survey.</p> <p>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:</p> |                                                                  |  | K0000                                                                                        |                                                                                                                                                                                                                                          |                                              | 08/07/2026                 |
| K0345<br>SS = F<br>Bldg. 01                                                      | <p>Fire Alarm System - Testing and Maintenance</p> <p>CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  |  | K0345                                                                                        | <p>Corrective Action:</p> <p>The facility scheduled and completed the required semiannual fire alarm initiating device inspection. Documentation has been obtained and placed in the Life Safety binder.</p> <p>Systemic Correction:</p> |                                              | 08/07/2026                 |



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| K0345<br>SS = F<br>Bldg. 01                                                      | <p>Continued from page 2</p> <p>Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 06/23/2026, at 10:55am, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Director that the facility could not provide current documentation verifying that a semiannual inspection of initiating devices had been completed. Document presented showed that the last time system was tested was 01/16/2026.</p> <p>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</p> |                                                                  |  | K0345                                                                                        | <p>Continued from page 2</p> <p>The Maintenance Director updated the TELS calendar to ensure all required fire alarm testing and inspections are scheduled timely.</p> <p>Monitoring:</p> <p>The Maintenance Director will review Life Safety documentation monthly to verify compliance.</p> <p>Responsible Person: Maintenance Director / Administrator</p> <p>Completion Date: Scheduled for 8/4/26</p>                                                                                                                                                           |                                              | 08/07/2026                 |
| K0353<br>SS = F<br>Bldg. 01                                                      | <p>Sprinkler System - Maintenance and Testing</p> <p>CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing</p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked</p> <p>_____</p> <p>b) Who provided system test</p> <p>_____</p> <p>c) Water system supply source</p> <p>_____</p> <p>Provide in REMARKS information on coverage for</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  |  | K0353                                                                                        | <p>Corrective Action:</p> <p>The facility contacted the sprinkler vendor and scheduled completion of the required five-year sprinkler inspection/testing. Documentation will be placed in the Life Safety binder.</p> <p>Systemic Correction:</p> <p>The Maintenance Director implemented a TELS calendar tracking all required inspections.</p> <p>Monitoring:</p> <p>The Maintenance Director will review inspection schedules monthly for ongoing compliance.</p> <p>Responsible Person: Maintenance Director / Administrator</p> <p>Completion Date: 6/28/26</p> |                                              | 08/07/2026                 |



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| K0353<br>SS = F<br>Bldg. 01                                                      | <p>Continued from page 3<br/>any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 06/23/2026, at 11:24am,it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing.</p> <p>An interview with Maintenance Director verified these deficient findings at the time of discovery.</p>                             |                                                                  |  | K0353                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                              | 08/07/2026                 |
| K0372<br>SS = F<br>Bldg. 01                                                      | <p>Subdivision of Building Spaces - Smoke Barrie</p> <p>CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction</p> <p>2012 EXISTING</p> <p>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility.</p> |                                                                  |  | K0372                                                                                        | <p>Corrective Action:</p> <p>The identified smoke barrier penetrations were repaired using approved fire-rated materials.</p> <p>Systemic Correction:</p> <p>The Maintenance Director completed a review of smoke barriers throughout the facility and educated staff to report any damaged barriers or penetrations.</p> <p>Monitoring:</p> <p>Smoke barriers will be reviewed during monthly environmental rounds.</p> <p>Responsible Person: Maintenance Director</p> <p>Completion Date: 6/26/26</p> |                                              | 08/07/2026                 |



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| K0372<br>SS = F<br>Bldg. 01                                                      | <div>Continued from page 4</div> <div>Findings include:</div> <div>On 06/23/2026 at the following times, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following locations:</div> <div>1) at 11:48am, Doors leading to Harbor Light patient wing.</div> <div>2) at 12:08pm, Doors leading to Morning Light west patient wing.</div> <div>3) at 12:09pm, Doors leading to Morning light west far doors on patient wing.</div> <div>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |  | K0372                                                                                        |                                                                                                                          |                                              | 08/07/2026                 |
| K0761<br>SS = F<br>Bldg. 01                                                      | <div>Maintenance, Inspection &amp; Testing - Doors</div> <div>CFR(s): NFPA 101</div> <div>Maintenance, Inspection &amp; Testing - Doors</div> <div>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</div> <div>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</div> <div>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.</div> <div>Written records of inspection and testing are maintained and are available for review.</div> <div>19.7.6, 8.3.3.1 (LSC)</div> <div>5.2, 5.2.3 (2010 NFPA 80)</div> <div>This STANDARD is NOT MET as evidenced by:</div> <div>1) Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.5.2. This deficient finding could have a widespread impact on the residents within the facility. 2) Based on a review of available</div> |                                                                  |  | K0761                                                                                        | Waiver Requested                                                                                                         |                                              | 08/07/2026                 |



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| (X4) ID<br>PREFIX<br>TAG                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                         |                                              | (X5)<br>COMPLETION<br>DATE |
| K0761<br>SS = F<br>Bldg. 01                                                      | <p>Continued from page 5</p> <p>documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 06/23/206, at 11:29am, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to provide a document showing all 13 points of the required door inspection was completed.</p> <p>Findings include:</p> <p>On 06/23/206, at 11:55am, it was revealed by observation that the fire doors and/or fire door frame tags on the Harbor Light patient wing doors were painted over and unreadable.</p> <p>An interview with the Maintenance Director verified this deficient finding at the time of discovery.</p> |                                                                  |  | K0761                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              | 08/07/2026                 |
| K0211<br>SS = E<br>Bldg. 01                                                      | <p>Means of Egress - General</p> <p>CFR(s): NFPA 101</p> <p>Means of Egress - General</p> <p>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.</p> <p>18.2.1, 19.2.1, 7.1.10.1</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 06/23/2026, at 12:20pm, it was revealed by observation that there was medical equipment in the egress corridor located on the Morning Light wing at</p>                                              |                                                                  |  | K0211                                                                                        | <p>Corrective Action:</p> <p>The medical equipment located in the corridor was immediately removed and relocated to an approved storage area.</p> <p>Systemic Correction:</p> <p>Staff were educated that corridors and exits must remain clear of equipment and storage items.</p> <p>Monitoring:</p> <p>Environmental rounds will include review of egress pathways.</p> <p>Responsible Person: Maintenance Director / Department Managers</p> <p>Completion Date: 6/26/26</p> |                                              | 08/07/2026                 |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245227 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X3) DATE SURVEY COMPLETED<br><br>06/23/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                            |
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| K0211<br>SS = E<br>Bldg. 01                                                      | Continued from page 6<br>end of corridor.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  |  | K0211                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              | 08/07/2026                 |
| K0223<br>SS = E<br>Bldg. 01                                                      | <div>Doors with Self-Closing Devices</div> <div>CFR(s): NFPA 101</div> <div>Doors with Self-Closing Devices</div> <div>Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</div> <div>* Required manual fire alarm system; and</div> <div>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</div> <div>* Automatic sprinkler system, if installed; and</div> <div>* Loss of power.</div> <div>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</div> <div>This STANDARD is NOT MET as evidenced by:</div> <div>Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have a patterned impact on the residents within the facility.</div> <div>Findings include:</div> <div>On 06/23/2026 at the following times, it was revealed by observation that storage room doors in smoke barrier walls did not have self-closing device that full closed and latched door when tested in the following areas.</div> <div>1) at 1:00pm, Harbor Light wing soiled utility room door did not close and latch on self-closer power when tested.</div> <div>2) at 1:16pm, storage room in the Park Breeze patient care area missing self-closer</div> <div>3) at 1:19pm, activities storage room on the Park Breeze patient care area door did not close and</div> |                                                                  |  | K0223                                                                                        | <div>Corrective Action:</div> <div>The identified doors were repaired and adjusted to ensure proper self-closing and latching operation.</div> <div>Systemic Correction:</div> <div>The Maintenance Director inspected smoke barrier doors throughout the facility.</div> <div>Monitoring:</div> <div>Door operation will be reviewed during monthly Life Safety rounds.</div> <div>Responsible Person: Maintenance Director</div> <div>Completion Date: 8/7/26</div> |                                              | 08/07/2026                 |



|                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  |  |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                            |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245227 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X3) DATE SURVEY COMPLETED<br><br>06/23/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              |                            |
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| K0223<br>SS = E<br>Bldg. 01                                                      | Continued from page 7<br>latch on self-closer power when tested                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  |  | K0223                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              | 08/07/2026                 |
| K0920<br>SS = E<br>Bldg. 01                                                      | <p>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</p> <p>Electrical Equipment - Power Cords and Extens</p> <p>CFR(s): NFPA 101</p> <p>Electrical Equipment - Power Cords and Extension Cords</p> <p>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a patterned impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 06/23/2026, at the following times, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas;</p> <p>1) at 12:51pm, Extension cords plugged into refrigerator in Therapy room</p> |                                                                  |  | K0920                                                                                        | <p>Corrective Action:</p> <p>Improper extension cords and power devices were immediately removed and corrected.</p> <p>Systemic Correction:</p> <p>Staff were educated regarding appropriate use of electrical equipment, power strips, and extension cords.</p> <p>Monitoring:</p> <p>Environmental rounds will include review of electrical equipment compliance.</p> <p>Responsible Person: Maintenance Director / Department Managers</p> <p>Completion Date: 6/26/26</p> |                                              | 08/07/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                            |
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| K0920<br>SS = E<br>Bldg. 01                                                      | Continued from page 8<br><br>2) at 1:31pm, in the Harbor Light dining room storage closet.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |  | K0920                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              | 08/07/2026                 |
| K0324<br>SS = D<br>Bldg. 01                                                      | Cooking Facilities<br><br>CFR(s): NFPA 101<br><br>Cooking Facilities<br><br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br><br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br><br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br><br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br><br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br><br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2, 9.2.3, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could have an isolated impact on the residents within the facility.<br><br>The findings include:<br><br>On 06/23/2026, at 12:32pm, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an |                                                                  |  | K0324                                                                                        | Corrective Action:<br><br>The wheeled gas stove and griddle were secured with appropriate attachment/alignment methods were performed by vendor.<br><br>Systemic Correction:<br><br>Dietary and Maintenance staff were educated regarding proper placement and safety requirements for movable cooking equipment.<br><br>Monitoring:<br><br>Kitchen inspections will verify equipment remains properly positioned.<br><br>Responsible Person: Dietary Director / Maintenance Director<br><br>Completion Date: 7/22/26 |                                              | 08/07/2026                 |



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| K0324<br>SS = D<br>Bldg. 01                                                      | Continued from page 9<br>approved method of attachment and/or an alignment<br>mark to ensure the appliances was returned to an<br>approved design location after it had been moved<br>for maintenance and cleaning. Both the attachment<br>device and alignment mark are required for each gas<br>operated and deep fat fryer cooking device.<br><br>An interview with the Maintenance Director verified<br>this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  | K0324                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              | 08/07/2026                 |
| K0355<br>SS = D<br>Bldg. 01                                                      | Portable Fire Extinguishers<br><br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br><br>Portable fire extinguishers are selected, installed,<br>inspected, and maintained in accordance with NFPA<br>10, Standard for Portable Fire Extinguishers.<br><br>18.3.5.12, 19.3.5.12, NFPA 10<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and staff interview, the facility<br>failed to maintain access to portable fire<br>extinguishers per NFPA 101 (2012 edition), Life<br>Safety Code, section 9.7.4.1, and NFPA 10 (2010<br>edition), Standard for Portable Fire Extinguishers,<br>section 7.3.1.1.1. This deficient finding could have an<br>isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 06/23/2026, at 11:29am, it was revealed by<br>documentation review that the fire extinguishers<br>annual inspection documentation could not be<br>provided.<br><br>An interview with the Maintenance Director verified<br>this deficient finding at the time of discovery. |                                                                  |  | K0355                                                                                        | Corrective Action:<br><br>Annual fire extinguisher inspection documentation<br>was obtained and placed in the Life Safety binder<br>from March of 2026.<br><br>Systemic Correction:<br><br>Fire extinguisher inspections were added to the<br>TELS calendar.<br><br>Monitoring:<br><br>The Maintenance Director will verify inspection<br>documentation monthly.<br><br>Responsible Person: Maintenance Director<br><br>Completion Date: 6/26/26 |                                              | 08/07/2026                 |
| K0921<br>SS = D<br>Bldg. 01                                                      | Electrical Equipment - Testing and Maintenanc<br><br>CFR(s): NFPA 101<br><br>Electrical Equipment - Testing and Maintenance<br>Requirements<br><br>The physical integrity, resistance, leakage current,<br>and touch current tests for fixed and portable<br>patient-care related electrical equipment (PCREE) is<br>performed as required in 10.3. Testing intervals are<br>established with policies and protocols. All PCREE<br>used in patient care rooms is tested in accordance<br>with 10.3.5.4 or 10.3.6 before being put into service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |  | K0921                                                                                        | Corrective Action:<br><br>The facility obtained TELS report showing inventory<br>of patient-care electrical equipment and established<br>required testing documentation will now be kept in<br>Life Safety Binder<br><br>Systemic Correction:<br><br>The facility reviewed electrical equipment policies<br>and educated staff regarding compliance<br>requirements.<br><br>Monitoring:                                                          |                                              | 08/07/2026                 |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245227 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                  |                                                                                                                                                                                                                                                  | (X3) DATE SURVEY COMPLETED<br><br>06/23/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>BAYSHORE RESIDENCE AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1601 ST LOUIS AVENUE , DULUTH, Minnesota, 55802 |                                                                                                                                                                                                                                                  |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                         |                                              | (X5)<br>COMPLETION<br>DATE |
| K0921<br>SS = D<br>Bldg. 01                                                      | <p>Continued from page 10</p> <p>and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.</p> <p>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to provide a policy for appliances not supplied by the facility per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 06/23/2026 at 11:45am, it was revealed by a review of available documentation that the facility could not provide documentation for the testing of electrically powered medical equipment.</p> <p>An interview with the Maintenance Director verified this deficient finding at the time of discovery.</p> |                                                                  |  | K0921                                                                                        | <p>Continued from page 10</p> <p>The Maintenance Director will maintain an electrical equipment tracking log and review compliance quarterly.</p> <p>Responsible Person: Maintenance Director / Administrator</p> <p>Completion Date: 8/7/26</p> |                                              | 08/07/2026                 |