DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL 'E SURVEY AGENCY	ID: GQM3 Facility ID: 00589
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245227 2.STATE VENDOR OR MEDICAID NO. (L2) 1821433426).	 NAME AND ADI (L3) BAYSHORE (L4) 1601 ST LOU (L5) DULUTH, M 	RESIDENCE & I JIS AVENUE		TR (L6) 55802	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
 EFFECTIVE DATE CHANGE OF OWN (L9) 07/01/2013 	ERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 04/23/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 139 (L37) (L38)	 139 (L18) 139 (L17) 19 SNF (L39) 	B. Not in Com Requireme ICF (L42)	ce With quirements Based On: cceptable POC pliance with Program nts and/or Applied W IID (L43)	/aivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
16. STATE SURVEY AGENCY REMARK See Attached Remarks	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):			
17. SURVEYOR SIGNATURE	NEII	Date :	05/23/2014	(L19)	18. STATE SURVEY AGENCY AP	
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	L OFFICE OR SINGLE STAT	'E AGENCY
 DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Parti 2. Facility is not Eligible 	cipate (L21)		PLIANCE WITH CI ITS ACT:	VIL	 Statement of Financi Ownership/Control I Both of the Above : 	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 01/22/1979	23. LTC AGREEMI BEGINNING I		4. LTC AGREEME ENDING DATE		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susj	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	nt 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
	B. Rescind Sus	pension Date:	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (02/28/2014	OF APPROVAL DAT	E		
	(L32)			(L33)	DETERMINATION APPRO	VAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Facility ID: 00589

CCN: 24-5227

On April 23, 2014 a Post Certification Revisit was completed at this facility to verify compliance of deficiencies issued at the time of the PCR completed on March 6, 2014 and uncorrected deficiencies cited at the time of standard survey completed on December 19, 2013. In addition, investigation of complaint numbers: H5227042, H5227044 and H5227045 were conducted. Based on our revisit, we have determined the facility has corrected the deficiencies issued puruant to our standard survey completed on December 19, 2013 and PCR completed on March 6, 2014, effective March 19, 2014.

As a result of the revisit findings, we recommended that the remedies imposed by the CMS Region V Office listed below remain in effect:

- Civil money penalty of \$3,200.00 for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
- Civil money penalty of \$3,000.00 for the deficiency cited at F333. (42 CFR 488.430 through 488.444)

In addition, we recommended the following action to the CMS Region V Office, they concurred with our recommendations and authorized this Department to notify the facility of the following:

• Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective March 19, 2014, be rescinded. (42 CFR 488.417 (b))

The facility would not be subject to a two year loss of NATCEP, since Mandatory Denial of Payment for New Medicare and Medicaid admissions did not go into effect.

Refer to the CMS 2567b form for the results of this visit.

Effective March 19, 2014, the facility is certified for 139 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5227

June 8, 2014

Mr. Mike Bosley, Administrator Bayshore Residence & Rehabilitation Center 1601 St Louis Avenue Duluth, Minnesota 55802

Dear Mr. Bosley:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 19, 2014 the above facility is certified for:

139 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 139 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

May 23, 2014

Mr. Mike Bosley, Administrator Bayshore Residence & Rehabilitation Center 1601 Saint Louis Avenue Duluth, Minnesota 55802

RE: Project Number S52270024, H5227042, H5227044 and H5227045

Dear Mr. Bosley:

On March 28, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective March 29, 2014. (42 CFR 488.422)

On March 26, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

Per instance civil money penalty of \$3,200.00 per instance for the deficiency cited at F309, effective January 13, 2014, for a total penalty of \$3,200.00. (42 CFR 488.430 through 488.444)
Per instance civil money penalty of \$3,000.00 per instance for the deficiency cited at F333, effective January 13, 2014, for a total penalty of \$3,000.00. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 19, 2014. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of March 26, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 19, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on December 19, 2013 and an abbreviated standard survey completed on January 13,2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 6, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), corrections were required.

On April 23, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 6, 2014, as of March 19, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 19, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 28, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 19, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 19, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 19, 2014, is to be rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 26, 2014:

• Per instance civil money penalty of \$3,200.00 per instance for the deficiency cited at F309, effective January 13, 2014, for a total penalty of \$3,200.00, remain in effect. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of \$3,000.00 per instance for the deficiency cited at F333, effective January 13, 2014, for a total penalty of \$3,000.00, remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of October 29, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 19, 2014. Since the primary Trigger of Denial of Payment for new Medicare and Medicaid admissions, did not go into effect, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Monh Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

cc: Licensing and Certification File

5227r2_14.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245227	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/23/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
BA	YSHORE RESIDENCE & REHAB CT	R	1601 ST LOUIS AVENUE DULUTH, MN 55802	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	()	(5) Da	ate
	F0157 483.10(b)(11)	Correction Completed 03/19/2014	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 03/19/2014		F0314 483.25(c)		Correction Completed 03/19/2014
ID Prefix Reg. # LSC	F0465 483.70(h)	Correction Completed 03/19/2014	ID Prefix Reg. # LSC						Correction Completed
ID Prefix Reg. # LSC			Reg. #			Reg. #			Correction Completed
Reg. #			Reg. #			Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #			D			Correction Completed
Reviewed E State Agen Reviewed E CMS RO	cy M	iewed By M/PH iewed By	Date: 05/22/201 Date:	4 29	of Surveyor: 9433 of Surveyor:			Date: Marcł Date:	n 19, 2014
Followup t	o Survey Complet 12/19/20			•	Uncorrected Defic d Deficiencies (CM		•	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY			e: GQM3 acility ID: 00589
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245227 2.STATE VENDOR OR MEDICAID NO. (L2) 1821433426	0.	 NAME AND ADI (L3) BAYSHORE (L4) 1601 ST LOU (L5) DULUTH, M 	RESIDENCE &		TR (L6) 55802		 TYPE OF ACTION: Initial Termination Validation 	7_(L8) 2. Recertification 4. CHOW 6. Complaint 9. Oci
5. EFFECTIVE DATE CHANGE OF OWN (L9) 07/01/2013 03/06/201		7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 C	CLIA	 7. On-Site Visit 8. Full Survey After Cor 	9. Other nplaint
6. DATE OF SURVEY HFC) 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 1 12/31	DATE: (L35)
 II. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	139 (L18)139 (L17)	X B. Not in Com	ce With quirements		And/Or Approved Wain 2. Technical Pe 3. 24 Hour RN 4. 7-Day RN (F 5. Life Safety C * Code: B	ersonnel Rural SNF)	Following Requirements: 6. Scope of Servic 7. Medical Directu 8. Patient Room Si 9. Beds/Room (L12)	Dr
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF 139	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j)	(1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AG	GENCY APP	PROVAL	Date:
Teresa Ament, HFE	NEII		04/08/2014	(L19)	Mark The	eith,	Enforcement Special	05/18/2014 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	LOFFICE OR SINGL	LE STATI	EAGENCY	
 DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Part <u>2</u>. Facility is not Eligible 	icipate (L21)		PLIANCE WITH C ITS ACT:	IVIL		ip/Control In	al Solvency (HCFA-2572) terest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINATION AC	CTION:	(1	.30)
OF PARTICIPATION 01/22/1979	BEGINNING	DATE	ENDING DATE	2	<u>VOLUNTARY</u> 01-Merger, Closure	00		ARY_ et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Rei		t 06-Fail to Me	et Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI				03-Risk of Involuntary Ter 04-Other Reason for Witho		<u>OTHER</u> 07 Provider S	Status Change
(L27)	 A. Suspension of B. Rescind Susp 		(L44)				00-Active	Status Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C.	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	Έ				
	(L32)	02/28/2014		(L33)	DETERMINATION	APPROV	/AL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: GQM3 Facility ID: 00589

CCN: 24-5227

C&T REMARKS - CMS 1539 FORM

On March 6, 2014 and on March 7, 2014 The Minnesota Department of Health, Licensing and Certification Program, and Office of Health Facility Complaints completed Post Certification Revisits (PCR) to verify correction of deficiencies issued at the time of the standard survey completed on December 19, 2013 and abbreviated standard survey completed on January 13, 2014 during the standard survey and abbreviated standard survey investigations of substantiated complaint numbers: H5227042, H5227044 and H5227045 were completed. On the March 6, 2014 PCR, investigation of complaint number H5227047 was completed and found to be substantiated. Base on the revisits we determined the facility was not in substantial compliance with three defiencies (F282, F314 and F468) issued pursuant to the standard survey completed on December 19, 2013 and abbreviated standard survey completed on January 13, 2014 and one new deficiency was cited. As a result of the revisit findings, this Department imposed the category one remedy of State monitoring, effective March 29, 2014.

In addition we recommended to the CMS RO, CMS RO concurred and authorized this Department to notify the facility of the following actions:

- Mandatory Denial of Payment for new Medicare and Medicaid admissions, effective March 19, 2014

STATE AGENCY REMARKS

Loss of NATCEP would also go into effect March 19, 2014 for a two year period, as a result of Mandatory denial of payment

Refer to the CMS 2567b forms and the CMS 2567 along with the facility's plan of correction. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

<u>REVISED</u>

Certified Mail # 7011 2000 0002 5143 7876

March 28, 2014

Mr. Mike Bosley, Administrator Bayshore Residence & Rehabilitation Center 1601 St Louis Avenue Duluth, Minnesota 55802

RE: Project Number S5227024, H5227042, H5227044 and H5227045

Dear Mr. Bosley:

This letter is revised as a result of two deficiencies (F170 and F323) that were cited at the time of the standard survey, but did not reflect correction at the time of our notice, when infact both deficiencies were corrected at the time of our March 6, 2013, Post Certification Revisit. In addition, enclosed is the CMS 2567b revisit form reflecting the two deficiencies as corrected. Please follow the March 24, 2014 letter for timelines and requirements.

On January 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2013 that included an investigation of complaint number H5227042, and on January 31, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department's Office of Health Facility Complaints for an abbreviated standard survey, completed on January 13, 2014. The surveys found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required. As a result of finding your facility not in substantial compliance, this Department recommended to the CMS Region V Office and they concurred and authorized this Department to notify you of the following remedy for imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 19, 2014. (42 CFR 488.417 (b))

The CMS Region V Office notified your fiscal intermediary that the denial of payment for new admissions is effective March 19, 2014. They also notified the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 19, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective March 19, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

On March 6, 2014, the Minnesota Department of Health and on March 7, 2014, the Minnesota Department of Healths Office of Health Facility Complaints completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 19, 2013 and an abbreviated standard survey completed on January 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 19, 2013 and an abbreviated standard survey completed on January 13, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores F0465 -- S/S: D -- 483.70(h) -- Safe/functional/sanitary/comfortable Environ

In addition, at the time of this revisit, we identified the following deficiencies:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)

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

As a result of our finding that your facility continues to not be in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective March 29, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the following remedy will remain in effect:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 19, 2014. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective March 19, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

> Patricia Halverson Licensing and Certification Program Minnesota Department of Health 11 East Superior Street, Suite #290 Duluth, Minnesota 55802

Phone: (218) 302-6151 Fax: (218) 723-2359

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of the March 24, 2014 letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of the March 24, 2014 letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 Office of Health Facility Complaints staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245227	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/6/2014
Name	of Facility		Street Address, City, State, Zip Code	
BA	YSHORE RESIDENCE & REHAB CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) It	em	(Y5)	Date	(Y4) Item	1	(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0162		01/28/2014	ID	Prefix	F0170		01/28/2014		ID Prefix	F0309		01/28/2014
0	483.10(c)(8)				-	483.10(i)(1)				-	483.25		
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix	E0242		Completed 01/28/2014		Drofiv	F0315		Completed 01/28/2014		ID Profix	F0323		Completed 01/28/2014
			01/28/2014					01/20/2014					01/28/2014
-	483.25(a)(3)					483.25(d)					483.25(h)		_
					LSC								_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0325		01/28/2014	ID	Prefix	F0333		01/28/2014		ID Prefix	F0441		01/28/2014
Reg. #	483.25(i)				Req. #	483.25(m)(2)				Reg. #	483.65		
LSC					LSC								_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix				ID	Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed	ID	Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #								
LSC										LSC			
									-				_
Reviewed By	/	Reviewed E	Зу	Date:		Signature of Su	irve	yor:				Date:	
State Agenc	/	MM/P	H	03/2	2/20	14		2943	33			03/0	6/2014
Reviewed By	/ <u> </u>	Reviewed E	Зу	Date:		Signature of Su	irve	yor:				Date:	
CMS RO													
Followup to	Survey Comple	ted on:				Check for	anv	Uncorrected D	Defi	ciencies. Was	a Summary of	1	
	12/19/	/2013					-				to the Facility?	YES	NO
				1									

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245227	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/7/2014
Name	of Facility		Street Address, City, State, Zip Code	
BA	YSHORE RESIDENCE & REHAB CTR		1601 ST LOUIS AVENUE	
			DULUTH, MN 55802	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		Y5)	Date
			Correction					Correction					Correction
ID Prefix	E0300		Completed 01/28/2014		ID Prefix	E0333		Completed 01/28/2014		ID Profix			Completed
			01/20/2014					01/20/2014					
Reg. # LSC	483.25					483.25(m)(2)				Reg. # LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			-					
Reg. # LSC					Reg. # LSC					Reg. #			
					200					200			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix								-					
Reg. #					Reg. #					Reg. #			
					100					200			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			-					
Reg. # LSC					Reg. #					Reg. #			
					100					200			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. # LSC					Reg. # LSC					Reg. #			
					130					130			
Reviewed By	/	Reviewed E	Зу	Dat	te:	Signature of	f Surve	yor:				Date:	
State Agency	y	MM/K	L	03	/22/20	14	28	8595				03/	07/2014
Reviewed By	/	Reviewed E	Зу	Dat	te:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Comple	eted on:					-				a Summary of		
	1/13/	2014				Unce	orrecte	d Deficiencies	s (CMS	-2567) Sent t	o the Facility?	YES	NO

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY
	F CORRECTION		A BUILDING		COMPLETED
		RECEIV	alla pica.		R-C
		245227	B WING		03/06/2014
IAME OF F	ROVIDER OR SUPPLIER	APRUI		TREET ADDRESS, CITY, STATE, ZIP CODE	
BAYSHO	RE RESIDENCE & RI	EHAB CTR	2997 I		
		Bittan,		ULUTH, MN 55802	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
{F 000}	INITIAL COMMEN	тѕ	{F 000}	\mathbb{O}	-8-14
	investigation for co	m OHFC completed an mplaint number H5227047. the stantiated with one example	1	constitutes Bayshore Residence and Rehabilitation Center's written allegation of compliance for the deficiencies cited.	
	deficiencies issued	v up was completed for I subsequent to complaint 33 corrected and F314		However, submission of this Pla of Correction is not an admissio that a deficiency exists or that one was cited correctly. This Pla	n
F 157 SS=D		TIFY OF CHANGES E/ROOM, ETC)	F 157	of Correction is submitted to	
	consult with the re known, notify the r or an interested fa accident involving injury and has the intervention; a sign physical, mental, of deterioration in he status in either life clinical complication significantly (i.e., a existing form of the consequences, or treatment); or a de	nediately inform the resident; sident's physician; and if resident's legal representative mily member when there is an the resident which results in potential for requiring physician inficant change in the resident's or psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ons); a need to alter treatment a need to discontinue an eatment due to adverse to commence a new form of ecision to transfer or discharge the facility as specified in		F 157 It is the practice of this facility to inform the resident; consult with the resident's physician; and if known, notify the resident's leg representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or decision to transfer or discharg the resident from the facility.	th gal
	and, if known, the or interested famil change in room o	also promptly notify the resident resident's legal representative ly member when there is a r roommate assignment as .15(e)(2); or a change in			

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

		AND HUMAN SERVICES				FORMA	03/21/2014 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•		E CONSTRUCTION	(X3) DATE COMP R-	LETED
		245227	B. WING	i			6/2014
	PROVIDER OR SUPPLIER	EHAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802	i i i i i i i i i i i i i i i i	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	regulations as spet this section. The facility must ret the address and polegal representative This REQUIREME by: Based on observative review, the facility and the resident's the change of stat residents (R171) r and for 1 of 1 resident's the change of stat respiratory distres Findings include: R171's Diagnosis diagnoses includine The quarterly Mini 1/29/14, indicated required extensive transfers and perso frequently incontine quarterly MDS fur for the developments stage 1 or greater admission, 2 unst eschar present, a devices on the ch	er Federal or State law or cified in paragraph (b)(1) of ecord and periodically update hone number of the resident's e or interested family member. ENT is not met as evidenced ation, interview and document failed to ensure the physician representative were notified in us of a pressure ulcer for 1 of 3 eviewed for pressure ulcers dents (R180) reveiwed for s. Report dated 3/6/14, indicated ng cerebrovascular disease. imum Data Set (MDS) dated R171 was cognitively intact, e assistance with bed mobility, sonal hygiene activities; and was nent of bowel and bladder. The ther indicated R171 was at risk ent of pressure ulcers, had a pressure ulcer present on ageable pressure ulcers, with nd had pressure reducing air and bed. A Care Area A) dated 11/4/13, indicated R171 essure ulcers and had a scab on		157	 <u>1. Corrective Action:</u> a. R 171 ulcers were assessed an the physician was notified regarding change and family updated regarding the change 3/5/14. b. R 180 admitted to the hospital 2/18/14 following a MD appointment. c. Training was done with the involved nursing staff as it related to notification of change and the necessity to notify the healthcare provider. <u>2. Corrective Action as it applies to other Residents:</u> a. An audit was done of resident who had perceived or actual changes in condition that should be reported to the healthcare provider. b. Concurrent review will be dot based on the 24 hour report to assure that and perceived changes have been communicated. c. Re-training was initiated of Licensed Staff on identification changes that should be reported to the provite to the provider/resident's legal representative and/or interester family member. 	l es e e ts d ne of d	

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/21/2014 APPROVEE 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY IPLETED
		245227	B. WING	; <u> </u>			06/2014
	PROVIDER OR SUPPLIER	EHAB CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 157	1/13/14, indicated I scab measuring 1. discolored purple a cm. on the left hee The fax physician's Solosite to scab, c Kerlix daily and rea different treatment R171's Care Plan indicated an unsta outer ankle with 10 directed to follow f skin injury and to r needed, monitor/d treatment of skin in failure to heal sign maceration to MD. Care Plan dated 1 adhesive, wound o A Skin Ulcer Data form dated 2/25/14 ulcer had healed. On 3/5/14, at 7:10 was observed dur ankle ulcer. RN-0 3/4/14, when the s the ulcer at 0.5 cm clean Curad dress covered the Curao gauze dressing ar dressing with a ro wrap in place.	lem Identification Assessment R171's left ankle had a loose 4 cm by 1.9 cm. and a area measuring 1.4 cm by 2.0 I. s order dated 1/14/14, directed over with gauze and wrap with assess after scab comes off for		157	 <u>3. Reoccurrence will be</u> prevented by: a. Licensed Staff will be retrained on identification of changes that must be reported the provider/resident's legal representative and/or interester family member. b. Daily meetings will include review of conditions that requinotification of the provider/ resident's legal representative and/or interested family member related to change in condition. <u>4. The Correction will be</u> monitored by: DON, Unit Managers and Designees with oversight by Nursing Home Administrator. Any variances will be immediately corrected and the activity will be reported throug the monthly QA/PI committee review. <u>5. Date of Completion: 3/19/</u> 	ed re ber gh for	

FORM CMS-2567(02-99) Previous Versions Obsolete

.

.

		AND HUMAN SERVICES				FORM A	03/21/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245227	B. WING	÷	·		6/2014
NAME OF F	PROVIDER OR SUPPLIER		L	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR		1	601 ST LOUIS AVENUE OLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 157	Continued From pa ulcer re-opened.	age 3	F	157			
	was responsible to DON further stated and/or the ulcer op responsible to notil resident's family, a A Change of Cond policy reviewed an resident's physicia	am, the DON stated RN-B assess and stage ulcers. The when the stage changed bened up, the RN would be fy the resident's physician, the nd also the dietician. ition/Special Needs Charting d revised 5/2011, directed the n would be contacted in a					
	resident experience not addressed through protocol. The polic resident's family/si	er verbally or written if the es a change in skin integrity, ough the facility's skin care cy further directed the gnificant other would be e is a change in status of a					
	change of condition distress. A progress note dat indicated R180 was her pain 10/10 in the were taken and ox pulse elevated to (HOB) was elevated pierce-lip breath. (narcotic used for [the] sharp pain in [oxygen saturation	o notify R180 's physician for on regarding respiratory ated 2/17/14, at 6:56 p.m. as calling out in pain and rated her back. R180 's vital signs kygen saturation was 73%, 110. R180 's head of bed ed, and she was instructed to R180 also received Roxenol pain) for breathing difficulties, [her] back decreased as sat h] rose. [R180] Will be hour report and vitals rechecked					

		AND HUMAN SERVICES				FORMA	03/21/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245227	B. WING			R-	C 6/2014
NAME OF	PROVIDER OR SUPPLIER	I		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.0	
					601 ST LOUIS AVENUE		
BAYSHC	RE RESIDENCE & RI	EHAB CTR		D	OULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	indicated that resid given 0.3 milligram Sulfate) per superviself, with pursed lip level [was] at 92%, nebulizer just being resident to be on for A progress note da Luke 's emergence they will be keepin diagnosis of Carbo diagnosis of pneur for a scheduled ap St. Luke 's ER. R180 was admitted that included acuted disease (COPD). had a focus area of included interventi sign/symptoms of to the MD (medical protocol. NA-H was intervie NA-H reported that times in the previo feel good and felt concerns to the LF complaints and the R180 was intervie R180 was intervie R180 was asked v day she was hosp was scheduled to the development of arrived at the cent and after a short t	ted 2/18/14, at 6:08 a.m. lent was in respiratory distress, s of MS Sulfate (Morphine visor request, resident calmed b breathing, oxygen saturation heart rate was up 112 due to g given, continue to monitor, bur hour vital sign checks. ated 2/18/14, indicated that St. y room (ER) called stating, g resident overnight with on Dioxide retention and new monia. Resident was sent out pointment and was referred to d on 12/9/13, with diagnoses e chronic obstructive pulmonary The care plan dated 12/20/13, of altered respiratory status that ons to observed for respiratory distress and report I doctor) PRN (as needed) per wed on 3/4/14, at 3:00 p.m. t R-180 had told her several us two weeks that she didn ' t foggy. NA-H reported these PN on duty at the time of the e LPN did go and talk with s that NA-A reported to were		157			

.

		AND HUMAN SERVICES				FORM /	03/21/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		245227	B. WING	i			06/2014
NAME OF F	ROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR					
					ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	Continued From pa	-	F	157		·	
		s having a lot of trouble ring difficulty staying awake and					
	answering the ther	apist 's questions, couldn 't					
		therapist was saying and the hospital. R180 was taken					
	to the emergency r	oom by the Medi-Van that had					
		the appointment. R180 stated ted to the Intensive Care Unit					
	with a diagnosis of	acute exacerbation of Chronic					
		nary Disease (COPD) with c respiratory failure.					
	R180 was then as	ked about the days leading up					
		on. R180 stated that she was sy with things like dropping					
	spoons and her ne	bulizer. R180 stated that she					
		e time. R180 reported that she east one week before being					
	hospitalized. R180	0 stated that she was having					
		athing. R180 stated that she e had requested to go to the					
		nes but they wouldn ' t send					
(.		that she reported these					
		.PN 's and they would come to but nothing was done, " they					
	didn ' t call my MD	" , and nurses wouldn ' t					
		e asked to go to the hospital. The was afraid because she felt					
		body would listen. R180 stated					
		re the hospitalization (2/17/14)					
		and in a lot of pain, she said preath, pulse was high and she					
	couldn ' t find a po	sition that was comfortable.					
		e asked LPN-A to send her to PN-A never provided her an					
	explanation as to	why R180 was not sent to the					
	hospital.	NI A was completed on 2/4/44					
		N-A was completed on 3/4/14, -A was asked what steps she					
		dent has a change in condition.					

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES				FORM A	PPROVED 0938-0391
			(X2) MU	TIPL	E CONSTRUCTION	(X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:					LETED
				- 01		R-	c.
		245227	B. WING		•	1	6/2014
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	00/0	0/2014
I NAME OF F	ROWDER OR SUPPLIER				601 ST LOUIS AVENUE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			ULUTH, MN 55802		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP	DBE	(X5) COMPLETION DATE
TAG	REGULATORTOR				DEFICIENCY)		
F 157	Continued From pa	200 6		157			
1 107		-	1	107			
		she will go to the resident and if they have PRN treatments or					
		build be tried, after that LPN-A					
		isor if there is no change.					
		ncident with R180 that					
		4, the night before R180 was					
) became short of breath,					
		k pain, her oxygen sat level					
		oulse was 110. LPN-A				Í	
		report the symptoms and					
		dent is requesting to go to the					
		A would consult with the MD. R180 was drug seeking and to					
		N-A reports that the resident					
		ver LPN-A didn 't agree with					
		ehavior and felt R180 was ill.					
		director of nursing (DON) was					
		14, at 4:30 p.m. The DON was					
	asked what the ex	pectation of the LPN/RN 's are					
	when a resident 's	s condition changes. The DON					
		ility expects the nurse to do a					
		nent prior to calling the					
		l or RN 's are able to call the					
		N ' s can take telephone orders.					
		d the physician would be called					
		condition changes. The					
		staff have a nursing supervisor with if there are any questions.					
) 's change in condition; the					
		ON receives regarding what					
		ngs and night shift didn ' t					
		condition or concerns.					
		ined medication aide (TMA-A)					
		3/6/14, at 11:25 a.m. TMA-A					
		nt involving R180 that occurred					
		roximately 7:00 - 7:30 p.m.					
		of distress on that shift, R180					
		the hospital, LPN-C went into					
	assess R180 LPN	I-C called RN-E and reported					

		AND HUMAN SERVICES			FC	FED: 03/21/2014 DRM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				NO. 0938-0391 DATE SURVEY COMPLETED
		245227	B. WING	i		R-C 03/06/2014
	PROVIDER OR SUPPLIER		l			
					REET ADDRESS, CITY, STATE, ZIP CODE	
BAYSHO	RE RESIDENCE & RI	EHAB CTR			ULUTH, MN 55802	
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 157	seeking behavior a TMA-A reported that that time. Interview of RN-E w involvement with R evening before R14 reported that she re- situation but does n she heard about it. the MD regarding R to call the MD. RN called. RN-E state to see R180 and th well. RN-E indicate notes or a log of ca- supervising. RN-E staff not to call an have documented record progress no significant event. W about R180 and if indicated that she from other staff an information to indic drug seeker. Interview of R180 M (MHT) was comple R180 was schedul in the afternoon. Th has been a client w years. The MHT w R180 had when sh The MHT stated th difficulties had bee	t RN-E felt R180 was drug nd to watch the resident. at the MD was not called at was completed on 3/7/14, at		157		
	2/18/14. R180 was	s very short of breath, had and she complained of being				

Facility ID: 00589

If continuation sheet Page 8 of 22

,

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY
	CONNECTION		A. BUILD	ING		F	R-C
		245227	B. WING				/06/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR)1 ST LOUIS AVENUE JLUTH, MN 55802		
		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	10N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION
F 157	conversation, there questions of up to a	age 8 aving difficulty focusing on the were delays in responding to 30 seconds and she was he conversation. The MHT	F	157			
{F 282} SS=D	stated that R180 to for at least a week worse. R180 told to her concerns to the several times but to that she had asked didn ' t think she ne The Change in Co Policy (revision dat The policy purpose physician, next of I or significant other change. The polic monitor changes of be documented. 483.20(k)(3)(ii) SE PERSONS/PER C The services provi-	old her that she has been sick and that she was getting the MHT that she had reported e nursing staff at the facility hey didn ' t do anything and d to go to the hospital but they eeded to go. Indition/Special Needs Charting te May 2011) was reviewed. e directed staff to: Notify the kin, designated contact person in the event of a status cy further directed staff to of condition and interventions to RVICES BY QUALIFIED	{F :	282}	F 282 It is the practice of this facility ensure the services provided of arranged by the facility should provided by qualified persons accordance with each residen written plan of care. <u>1. Corrective Action:</u> R 181's and R 171's care plans were reviewed. The issue rela	or be in t's	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care as directed by the plan of care for 2 of 3 residents (R181, R171) reviewed for pressure ulcers.				to turning and repositioning w cared for and the involved sta as well as other staff were re- trained on the need for repositioning. Staff were also trained on assuring that adap	ff re- tive	
	Ermungs include:	dings include: 31 was not provided timely repositioning for a			equipment including booties a	210	1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G		E SURVEY
		245227				R-C /06/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
	RE RESIDENCE & RI	EHAB CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 282}	presenting as shall pressure ulcer. R181's admission dated 12/20/13, ind cognitively impaire assist of 2 staff for and extensive assi MDS further indica development of a p had a stage 2 pres R181's care plan, was admitted with coccyx and directer repositioning in be two hours, and as R181 was not pro- continuous observ- until 12:55 p.m A into bed. RN-B me as 2.4 cm x 4 cm, On 3/4/14, at 2:37 (DON) stated that minimal, some res frequent reposition getting worse, or in pain. The DON fu staff to reposition care plan. The facility policy ulcers revised 5/1 impaired skin inter	Advised to the set of		 2) 2. Corrective Action as it appring to other Residents: a. An audit of residents to enthose that need repositioning a scheduled basis are identifiand actions taken to assure activity is occurring. b. An audit of resident care and group sheets whom requessitioning and/or device applications to ensure that the activity is occurring, as wee adding appropriate intervent as needed. 3. Reoccurrence will be prevented by: a. Initiated re-training of nustaff on the reed for repositioning, application of devices and overall skin carrinterventions. b. Residents identified as has special needs related to tur and repositioning and/or application of special device be checked to assure that the activity is occurring as listed the care plans and group sheets 	nsure g on ied this plans uire this as itions rsing f e aving ning es will his d on	

CENTEF STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	NG_		FORM <u>//B NO.</u> (X3) DATE COM	03/21/2014 APPROVED 0938-0391 E SURVEY PLETED -C
		245227	B. WING			03/0	06/2014
	PROVIDER OR SUPPLIER	EHAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE OULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	accordance with pl staff provide skin o protocol which has medical director ar orders. The facility policy a comprehensive ca each resident's co designed to aid in in the resident's fu functional levels. R171 was not com- pressure-relieving ulcer; in addition th assessed or treates standing orders or The quarterly MDS was at risk for the ulcers, had a stag present on admiss ulcers, with escha reducing devices of An Initial Skin Pro 1/13/14, indicated have a loose scate The Assessment a had a discolored p by 2.0 cm. The Care Plan da indicated R171 ha ulcer on left outer was present on admiss	n care is provided in hysician's orders. The facility are according to a standard been approved by the facility's and is included in the standing and procedure on re plans revised 10/10, directed mprehensive care plan is preventing or reducing declines nctional status and/or sistently provided devices for a left lateral heel he left lateral heel ulcer was not ed as directed by facility		282}	c. Items will be listed on the facility rounds sheets to validate through concurrent walking audits that the activity is occurring. <u>4. The Correction will be monitored by:</u> DON, Unit Managers and Designees with oversight by Nursing Home Administrator. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI committee for review. <u>5. Date of Completion: 3/19/14</u>	or	

FORM CMS-2567(02-99) Previous Versions Obsolete

CENTERS FOR MEDICARE & M					OMB NO	APPROVED 0938-0391			
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE				
	245227	B. WING			R-	C 6/2014			
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE						
			1	601 ST LOUIS AVENUE					
BAYSHORE RESIDENCE & REHAE	BCIR	ļ	D	DULUTH, MN 55802					
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ET BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE			
skin injury and to notify needed, monitor/docum treatment of skin injury, failure to heal signs and maceration to MD. The directed R171 needed a bilateral heel protectors Physician's orders date Solosite to scab, cover Kerlix daily and reasses different treatment. A Skin Ulcer Data Colle form dated 2/25/14, ind ulcer had healed. On 3/5/14, at 7:10 a.m. was observed during a R171's left ankle. The of RN-C stated the left an 3/4/14, when the scab measured the ulcer at the a clean Curad dressing gauze dressing and wr dressing with rolled gat slipper to R171's left fo blue booties was lying other on the bedside ta observed to be resting white sock on the right On 3/5/14, at 8:00 a.m ulcer was observed wit the brown slipper shoe R171's left foot/ankle.	s. The Care Plan y protocols for treatment of physician for orders as nent location, size, and , report abnormalities, d symptoms of infection, e Care Plan further assistance to apply d 1/14/14, directed with gauze and wrap with ss after scab comes off for ection and Assessment dicated R171's left ankle . registered nurse (RN)-C dressing change to dressing was removed and kle ulcer had reopened on had fallen off. RN-C 0.5 cm by 0.6 cm., applied g, added a 4 by 4 inch rapped the ankle and uze. RN-C applied a brown bot. One of R171's quilted on the dresser and the able. R171's right heel was on the bed with only a : foot. ., R171's left lateral ankle th RN-B. RN-B removed		.82}						

Facility ID: 00589

		AND HUMAN SERVICES				FORM	: 03/21/2014 APPROVED . 0938-0391
STATEMENT OF DEFINAND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA COI	TE SURVEY MPLETED
		245227	B. WIN	G			R-C / 06/2014
NAME OF PROVIDE	R OR SUPPLIER			(REET ADDRESS, CITY, STATE, ZIP CO	DE	
BAYSHORE RES	DENCE & RI	EHAB CTR		-	01 ST LOUIS AVENUE JLUTH, MN 55802		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	IC PRE TA	FIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
and g ankle physic press she c vaseli not ap On 3/ interv stand stated re-op based furthe nurse of orc R171 vasel not n and t treatr On 3, furthe nurse of orc R171 vasel not n and t treatr On 3, furthe nurse of orc R171 vasel not n and t treatr On 3, furthe nurse of orc R171 vasel not n and t treatr On 3, furthe not n and t treatr On 3, furthe nurse furthe nurse furthe nurse furthe nurse furthe nurse furthe nurse furthe nurse furthe nurse furthe nurse furthe nurse furth	ulcer was sta sian and fami ure ulcer reop hanged R17 ne dressing of 5/14, at 9:45 iewed. RN-B ing orders for when R171 ened, she de d on her would r stated she practitioner lers when an 's ulcer treath ine-type dress otified of the nere was no nent. '5/14, at appr ved seated i es' station we n slipper sho '5/14, at 11:4 erviewed and ss and stage the stage ch e RN would ent's physicia the dietician.	RN-B stated the left lateral age 2. RN-B confirmed the ily were not notified when the pened on 3/4/14. RN-B stated 1's ulcer treatment to a daily with dry gauze. RN-B did eft blue-quilted heel boot. a.m. the DON and RN-B were stated she was unaware of ar r wound care. RN-B further 's healed left lateral ankle ulce cided on a different treatment nd care experience. RN-B does not usually contact the or the physician with a change ulcer opens up. RN-B verified ment was changed to a ssing and R171's physician wa change in condition of the ulce physician's order to change th roximately 10:45 a.m. R171 wa in wheelchair in hallway near earing white stockings and	y r as ad d	282}			

•

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245227	B. WING	i			-C) 6/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAVSHO	RE RESIDENCE & RI				601 ST LOUIS AVENUE		
DATONG				D	OULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
{F 282} {F 314} SS=D	protocol to cover ul stated R171's left la stage 2 when the s confirmed she was ulcer opening up u 483.25(c) TREATM PREVENT/HEAL F Based on the comp resident, the facility who enters the fac does not develop p individual's clinical they were unavoid pressure sores rec services to promot prevent new sores This REQUIREME by: Based on observa review, the facility care of pressure u R171) reviewed fo Findings include: Pressure Ulcer Sta Pressure Ulcer Ad Stage I: Non-bland Intact skin with no localized area usu The area may be cooler as compare Stage II: Partial th Partial thickness la	cer care changes. The DON ateral ankle ulcer would be cab/eschar fell off. The DON not made aware of R171's ntil this morning. IENT/SVCS TO PRESSURE SORES orehensive assessment of a 7 must ensure that a resident ility without pressure sores oressure sores unless the condition demonstrates that able; and a resident having reves necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced ation, interview and document failed to provide appropriate locers for 2 of 3 residents (R181, r pressure ulcers. ages (defined by the National visory Panel) chable erythema n-blanchable redness of a ally over a bony prominence. painful, firm, soft, warmer or ed to adjacent tissue.		314}	F 314 It is the practice of this facility that based on the comprehensive assessment of a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and service to promote healing, prevent infection and prevent new sores from developing. <u>1. Corrective Action:</u> R 181's and R 171's care plans were reviewed. The issue relate to turning and repositioning was cared for and the involved staff as well as other staff were re- trained on the need for repositioning. Staff were also re trained on assuring that adaptiv equipment including booties are in place to relieve pressure.	ed s	

FORM CMS-2567(02-99) Previous Versions Obsolete

.

Facility ID: 00589

If continuation sheet Page 14 of 22

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU			(X3) DATE :	1938-039 SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:				COMPL	ETED
		245227	B. WING			R-0 03/00	5 5/2014
NAME OF F	PROVIDER OR SUPPLIER	A		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR			01 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
{F 314}	without slough. Ma open/ruptured seru filled blister. Prese ulcer without sloug Unstageable/Uncla tissue loss - depth Full thickness tissu the ulcer is comple (yellow, tan, gray, g (tan, brown or blac enough slough and expose the base of cannot be determin R181 was not provistage 2 coccyx pre- R181's admission Alzheimer's diseas osteoporosis. The (MDS) dated 12/20 severely cognitive extensive assist of transfers, and exter toileting. The MDS risk for the develop	y also present as an intact or im-filled or sero-sanginous nts as a shiny or dry shallow h or bruising. assified: Full thickness skin or unknown te loss in which actual depth of tely obscured by slough green or brown) and/or eschar kk) in the wound bed. Until d/or eschar are removed to f the wound, the true depth ned.	{F 3	114}	 2. Corrective Action as it applies to other Residents: a. An audit of resident care plans and group sheets who have pressure sores or who are at risk based on the comprehensive assessment has been completed to ensure that an appropriate repositioning plan of care is in place. Also residents who have devices were reviewed and a plan put in place to assure this activity occurs. 3. Reoccurrence will be prevented by: a. Initiated re-training of nursing staff on the reed for repositioning, application of devices and overall skin care interventions. b. Residents identified as having special needs related to turning and repositioning and/or 	1	
	was admitted with coccyx and directer repositioning in be two hours, and as assistant group sh offer toileting ever repositioning was	dated 12/19/13, indicated R181 a stage 2 pressure ulcer on the ed staff assistance significant d and when in wheelchair every needed. Although the nursing neet directed staff to check and y two hours and as needed, not addressed. ously observed on 3/4/14, from			application of special devices will be checked to assure that this activity is occurring as listed on the care plans and group sheets. c. Items will be listed on the facility rounds sheets to validate through concurrent walking audits that the activity is occurring.		

Facility ID: 00589

T OF HEALTH	AND HUMAN SERVICES				FORM A	PPROVED
R MEDICARE	& MEDICAID SERVICES					
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
					R-0	c
	245227	B. WING			03/0	6/2014
ER OR SUPPLIER						
SIDENCE & RE	EHAB CTR					
		<u> </u>			<u>. </u>	()(E)
EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
inued From pa ctivity, then toil 10:22 a.m. R1 ity room and a 0 a.m. R181 w finished feedin 2 p.m., R181 h out repositionir istered nurse ()-B were inform sitioning and F room at 12:54. way to the dinin 1 required ever p.m. NA-B pa isured R181's and stated it w 3/4/14, at 2:37 N) and RN-B v directed all de ry two hour rep ed that every the residents ma ositioning if the se, or if the residents ma ositioning if the se, or if the residents ma osition residents and stated skin integor ording to a stated facility policy area skin integor ording to a stated her directed skin integor ording to a stated for a stated skin integor ording to a stated for a stated skin integor ording to a stated her directed skin integor ording to a stated for a stated skin integor ording to a stated for a stated skin integor ording to a stated her directed skin integor ording to a stated skin integor ording to a	age 15 leted by staff from 10:10 a.m. 81 was brought back into the ind then to the dining room at as served lunch at 12:11 p.m., g herself at 12:49 p.m. At had been in the wheelchair ng for 2 hours and 30 minutes. RN)-B and nursing assistant hed of R181's lack of R181 was wheeled to the p.m NA-B stated she was on ng room to get R181 and knew ry two hour repositioning. At it R181 into bed. RN-B pressure ulcer as 2.4 cm x 4 vas a stage 2. p.m. the director of nursing were interviewed. RN-B stated pendent residents to have an positioning plan. The DON wo hours would be minimal, ay require more frequent pressure ulcer was getting sident was experiencing pain. stated she would expect staff to ts as directed by their care plan. and procedure on pressure 1, directed residents with grity receive treatment ndard protocol that meets ice. The policy and procedure in care is provided in hysician's orders. The facility care according to a standard s been approved by the facility's	{F 3		DEFICIENCY) <u>4. The Correction will be</u> <u>monitored by:</u> DON, Unit Managers and Designees with oversight by Nursing Home Administrator. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI committee fo review.	r	
	ER OR SUPPLIER FICIENCIES RECTION ER OR SUPPLIER SIDENCE & RE SUMMARY STA (EACH DEFICIENCY EGULATORY OR L Investigation of the tinued From particular tity room and a 0 a.m. R181 w finished feedin 2 p.m., R181 h out repositioning istered nurse ()-B were inform particular of the p.m. NA-B put astrong and F room at 12:54. way to the dining 1 required ever p.m. NA-B put astrong and R 1 required ever p.m. Salar and stated it w 3/4/14, at 2:37 N) and RN-B v directed all de ry two hour represent astrong if the se, or if the response of the se poon further se poonding to a stand and ards of practic her directed skin integor ording to a stand dards of practic her directed skin integor ording to a stand her directed skin integor ording to a stand	R MEDICARE & MEDICAID SERVICES FIGENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245227 ER OR SUPPLIER ESIDENCE & REHAB CTR SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) tinued From page 15 ctivity, then toileted by staff from 10:10 a.m. 10:22 a.m. R181 was brought back into the ity room and and then to the dining room at 0 a.m. R181 was served lunch at 12:11 p.m., finished feeding herself at 12:49 p.m. At 2 p.m., R181 had been in the wheelchair out repositioning for 2 hours and 30 minutes. istered nurse (RN)-B and nursing assistant)-B were informed of R181's lack of usitioning and R181 was wheeled to the room at 12:54, p.m NA-B stated she was on way to the dining room to get R181 and knew 1 required every two hour repositioning. At p.m. NA-B put R181 into bed. RN-B sured R181's pressure ulcer as 2.4 cm x 4 and stated it was a stage 2. 3/4/14, at 2:37 p.m. the director of nursing N) and RN-B were interviewed. RN-B stated directed all dependent residents to have an ry two hour repositioning plan. The DON ed that every two hours would be minimal, he residents may require more frequent ositioning if the pressure ulcer was getting se, or if the resident was experiencing pain. DON further stated she would expect staff to osition residents as directed by their care plan. effacility policy and procedure on pressure ers revised 5/11, directed residents with	IR MEDICARE & MEDICAID SERVICES FICIENCIES FICIENCIES IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245227 B. WING EER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES FEACH DEFICIENCY MUST BE PRECEDED BY FULL FEGULATORY OR LSC IDENTIFYING INFORMATION) Thus a strange of the transmitter of the dining room at 0 a.m. R181 was brought back into the divity room and and then to the dining room at 0 a.m. R181 was brought back into the divity room and and then to the dining room at 0 a.m. R181 was served lunch at 12:11 p.m., finished feeding herself at 12:49 p.m. At 2 p.m., R181 had been in the wheelchair out repositioning for 2 hours and 30 minutes. istered nurse (RN)-B and nursing assistant -B were informed of R181's lack of seitioning and R181 was wheeled to the room at 12:54, p.m NA-B stated she was on way to the dining room to get R181 and knew 1 required every two hour repositioning. At p.m. NA-B put R181 into bed. RN-B usured R181's pressure ulcer as 2.4 cm x 4 and stated it was a stage 2. 3/4/14, at 2:37 p.m. the director of nursing N) and RN-B were interviewed. RN-B stated directed all dependent residents to have an ry two hour repositioning plan. The DON ed that every two hours would be minimal, he residents way require more frequent ositioning if the pressure ulcer was getting se, or if the resident was experiencing pain. DON further stated she would expect staff to osition residents as directed by their care plan. P facility policy and procedure on pressu	R MEDICARE & MEDICAID SERVICES FIGIENCIES FIGIENCIES RECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245227 B. WING ER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES ESIDENCE & REHAB CTR SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) This definition This definition 10:22 a.m. R181 was brought back into the ity room and and then to the dining room at 0 a.m. R181 was served lunch at 12:11 p.m., finished feeding herself at 12:49 p.m. At 2 p.m., R181 had been in the wheelchair out repositioning for 2 hours and 30 minutes. istered nurse (RN)-B and nursing assistant)-B were informed of R181's lack of ositioning and R181 was wheeled to the room at 12:54. p.m NA-B stated she was on way to the dining room to get R181 and knew 1 required every two hour repositioning. At p.m. NA-B put R181 into bed. RN-B sured R181's pressure ulcer as 2.4 cm x 4 and stated it was a stage 2. 3/4/14, at 2:37 p.m. the director of nursing IN) and RN-B were interviewed. RN-B stated directed all dependent residents to have an ry two hour repositioning plan. The DON ed that every two hours would be minimal, he residents may require more frequent setioning if the pressure ulcer was getting se, or if the resident was experiencing pain. DON further stated she would expect staff to ostiton residents as directed by their care plan. P.m. Stated she would expect staff to osticin residents as directed by their care plan. P.M. fully policy an	IR. MEDICARE & MEDICAID SERVICES OI Indextriction NUMBER (22) MULTIPLE CONSTRUCTION Indextriction NUMBER (23) MULTIPLE CONSTRUCTION ER OR SUPPLIER 245227 ISTREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCY ID SUMMARY STATEMENT OF DEFICIENCY ID Inclued From page 15 (F 314) citvity, then toileted by staff from 10:10 a.m. (F 314) 10 2.2 a.m. R181 was brought back into the Interformed of R18'1'S lack of stitoning and R181 was wheeled to the Incluer as 2.4 cm x 4 and stated it was a stage 2. 3/4/14, at 2:37 p.m. the director of nursing N) and RN-B were interviewed. RN-B stated Incluer as 2.4 cm x 4 and stated it was a stage 2. 3/4/14, at 2:37 p.m. the director of nursing N) and RN-B were interviewed. RN-B stated Inthe wore sight have an is cold	IR MEDICARE & MEDICAID SERVICES OMB NO.2 INDERNOES (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILING (X3) DATE COMP R-4 245227 A BUILING (X3) MULTIPLE CONSTRUCTION A BUILING (X3) DATE COMP R-4 245227 A WING (X3) MULTIPLE CONSTRUCTION A BUILING (X3) DATE COMP R-4 250ENCE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE 1691 ST LOUS AVENUE DULUTH, MN S5802 (X4) MULTIPLE CONSTRUCTION A BUILING (X3) DATE COMP R-4 3000 SUMMARY STATEMENT OF DEFICIENCIES EQUATORY OR LSC IDENTIFYING INFORMATION ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION STATULE BE CROSS-REFERENCED TO THE APROPRATE DULUTH, MN S5802 DULUTH, MN S5802 3000 SUMMARY STATEMENT OF DEFICIENCIES EQUATORY OR LSC IDENTIFYING INFORMATION ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION STATULE BE CROSS-REFERENCED TO THE APROPRATE DULUTH, MN S5802 DULUTH, MN S5802 3000 SUMMARY STATEMENT OF DEFICIENCIES EQUATORY OR LSC IDENTIFYING INFORMATION ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION STATULE BE CROSS-REFERENCED TO THE APROPRATE DEFICIENCY 311 SUMMARY STATEMENT OF DEFICIENCIES INTEGRATION TO MARK AND STATE TO THE APROPRATE DULUTH, MN SERVERAN OF AN AND STATE STATE STATE STATE ACTION STATULE BE CROSS-REFERENCED TO THE APROPRATE DULUTH, MN SERVERAN OF AN A STATE STATUS AND

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00589

If continuation sheet Page 16 of 22

4

	MENT OF HEALTH							FORMA	03/21/2014 PPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			r	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
245227			B. WING				R-C 03/06/2014		
NAME OF F	PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP	CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR				01 ST LOUIS AVENUE ULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FUĽL	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD	BE	(X5) COMPLETION DATE
{F 314}	Continued From pa	Continued From page 16		{F 3	14}				
	ulcer; in addition th	devices for a left lat le left lateral heel uid d as directed by fac	cer was not						
		t dated 3/6/14, indic included cerebrovas							
	The quarterly MDS dated 1/29/14, indicated R17 was cognitively intact, required extensive assistance with bed mobility, transfers and personal hygiene activities, and was frequently incontinent of bowel and bladder. The quarterly MDS further indicated R171 was at risk for the development of pressure ulcers, had a stage 1 o greater pressure ulcer present on admission, 2 unstageable pressure ulcers, with eschar presen and had pressure reducing devices on the chair and bed. A Care Area Assessment (CAA) dated 11/4/13, indicated R171 was at risk for pressure ulcers and the left ankle bone had a scab. The CAA further indicated R171's extrinsic risk factor included pressure with interventions of needing a special mattress or seat cushion to reduce or relieve pressure and requiring a regular schedule of turning.		ive and requently e quarterly k for the a stage 1 or hission, 2 har present, the chair CAA) dated r pressure cab. The risk factor f needing a duce or ar schedule						
	1/13/14, indicated bruise. The Asses left ankle was note measuring 1.4 cm also indicated R17	blem Identification A R171 had an ulcer ssment further indicated to have a loose s by 1.9 cm. The As 71's left heel had a c uring 1.4 cm by 2.0	and a ated R171's cab sessment discolored						
		dated and revised	· · · · · · · · · · · · · · · · · · ·						
FORM CMS-2	2567(02-99) Previous Versior	ns Obsolete	Event ID: GQM3	312	Fa	acility ID: 00589	If continuat	tion sheet	Page 17 of 22

		AND HUMAN SERVICES				FORMA	03/21/2014 PPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
245227			B. WING			R-C 03/06/2014		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
BAYSHO	RE RESIDENCE & RE	EHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	Continued From parindicated actual im related to an abrass elbow, left hip, sca and several scabs ankle. The Care P indicated R171 had ulcer on left outer a was present on ad treatment of Allevy dressing] per MD of directed to follow fa skin injury and to m needed, monitor/do treatment of skin ir failure to heal sign maceration to MD. directed R171 nee bilateral heel prote The undated nursi directed R171 was heel/foot at all time A Patient Informatid dated 1/14/14, ind measuring 1.4 cm off on left ankle. T indicated the nurse receive orders to a with gauze and wr reassess after sca treatment. A Skin Ulcer Data form dated 2/25/14 ulcer had healed.	Age 17 pairment to skin integrity ion to the left outer leg, left bbed areas to the left knee, to lower legs and left outer than note dated 12/26/13, d an unstageable pressure ankle with 100% eschar that mission to the facility with n [adhesive wound care orders. The Care Plan acility protocols for treatment of notify physician for orders as ocument location, size, and hjury, report abnormalities, s and symptoms of infection, The Care Plan further ded assistance to apply octors. ng assistant assignment sheet is to have the blue boot on left es. ion Fax for order requested icated R171 had a thick scab by 1.9 cm, loose and coming The order requested fax further e was requesting and did apply Solosite to scab, cover rap with Kerlix daily and ab comes off for different Collection and Assessment 4, indicated R171's left ankle An electronic progress note	тас {F 3	•	CROSS-REFERENCED TO THE APPRO		DATE	
	was closed, with s	icated R171's left ankle area some discoloration around the area was blanchable with no						

Facility ID: 00589

If continuation sheet Page 18 of 22

		AND HUMAN SERVICES				FORM	03/21/2014 APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245227			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
			B. WING)			R-C 03/06/2014	
NAME OF F	PROVIDER OR SUPPLIER	J	.1	1	REET ADDRESS, CITY, STATE, ZIP C	ODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR			01 ST LOUIS AVENUE ULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 314}	area would be left note further descril discolored area me which was blanch On 3/5/14, at 7:10 was observed duri R171's left ankle. RN-C stated the le 3/4/14, when the s stated R171's left unstageable with a drainage on the ol the ulcer at 0.5 cm Curad dressing, at dressing and wrap with rolled gauze. to R171's left foot. booties was lying the bedside table. observed to be rea white sock on the On 3/5/14, at 7:11 lateral ankle ulcer further stated she when the ulcer re- or report the chan was to wear the q bed. RN-B stated area was another ulcer. On 3/5/14, at 8:00 ulcer was observed the brown slipper R171's left foot/ar	s note further indicated the open to the air. The progress bed R171's left heel with a easuring 1.7 cm by 2.0 cm, able and non-painful. a.m. registered nurse (RN)-C ng a dressing change to The dressing was removed and ft ankle ulcer had reopened on cab had fallen off. RN-C lateral ankle ulcer was a reddened wound bed and no d dressing. RN-C measured by 0.6 cm., applied a clean dded a 4 by 4 inch gauze oped the ankle and dressing RN-C applied a brown slipper One of R171's quilted blue on the dresser and the other or R171's right heel was sting on the bed with only a right foot. a.m. RN-B stated R171's left was unstageable. RN-B assessed the ulcer on 3/4/14, opened, but did not document ge. RN-B further stated R171 uilted blue booties daily while ir d R171's left heel discolored pressure unstageable pressure 0 a.m., R171's left lateral ankle ed with RN-B. RN-B removed shoe and the dressing on nkle. RN-B measured the ulcer lressing, a 4 by 4 inch gauze		314}	acility ID: 00589	f continuation she	et Page 19 of	

		AND HUMAN SERVICES				FORM AF	03/21/2014 PROVED 938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	.ETED
		245227	B. WING			R-C 03/06	5 5/2014
NAME OF P	ROVIDER OR SUPPLIER		· · · · ·		REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR			JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	ankle ulcer was sta physician and fami pressure ulcer reor she changed R17 vaseline dressing of not apply R171's left On 3/5/14, at 9:45 interviewed. RN-B standing orders fo stated when R171 re-opened, she de based on her wour further stated she nurse practitioner of orders when an R171's ulcer treat vaseline-type dress not notified of the and there was no treatment. On 3/5/14, at appr observed seated in nurses' station we brown slipper sho On 3/5/14, at 11:4 re-interviewed and assess and stage when the stage of up, the RN would resident's physicia also the dietician. expect the ulcers weekly and the re- weekly skin shee	RN-B stated the left lateral age 2. RN-B confirmed the pened on 3/4/14. RN-B stated 1's ulcer treatment to a daily with dry gauze. RN-B did eft blue-quilted heel boot. a.m. the DON and RN-B were stated she was unaware of any r wound care. RN-B further 's healed left lateral ankle ulcer ecided on a different treatment nd care experience. RN-B does not usually contact the or the physician with a change ulcer opens up. RN-B verified ment was changed to a ssing and R171's physician was change in condition of the ulcer physician's order to change the roximately 10:45 a.m. R171 was in wheelchair in hallway near earing white stockings and es. 0 am, the DON was d stated RN-B was required to a ulcers. The DON further stated hanges and/or the ulcer opened be responsible to notify the an, the resident's family, and The DON confirmed she would to be monitored and assessed esults documented either on the t or in the progress notes. The	s d	314}			
L	DON stated the fa	acility had standing orders and a	1		<u> </u>		Baga 20 of 2

Facility ID: 00589

		AND HUMAN SERVICES			FORMAPPR	
		& MEDICAID SERVICES	r		OMB NO. 0938	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURV COMPLETER	
		245227	B. WING _		03/06/20	14
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00100120	
BVAR	RE RESIDENCE & RI			1601 ST LOUIS AVENUE		
DAISHO				DULUTH, MN 55802		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMP	(X5) PLETION DATE
{F 314}	protocol to cover u stated R171's left l stage 2 when the s confirmed she was ulcer opening up u	Icer care changes. The DON ateral ankle ulcer would be cab/eschar fell off. The DON not made aware of R171's	{F 31	4}		
{F 465} SS=D	computer print out indications for use heel pillows provid breakdown, heel d shearing and/or sk the heel pillow's m information descrif relieving or reducin 483.70(h)	of the DeRoyal Heel Pillows The print out indicated the ed protection against skin ecubitus ulcer prevention, skin in friction. The DON confirmed anufacturer's indications lacked bing the product as pressure		F 465 It is the practice of this facili	y to	
		rovide a safe, functional, fortable environment for d the public.		provide a safe, functional, sanitary, and comfortable environment for residents, s and the public. 1. Corrective Action:	taff	
	by: Based on observa review the facility were kept clean for residents. Findings include: On 3/3/14, at 5:22 observed in the se wheelchair had m frame, foot rests,	ENT is not met as evidenced ation, interview and document did not ensure wheelchairs or 2 of 3 (R199, R145) e.cond floor dining room. The ultiple old food spills on the and the seat. R145 was nultiple times while attempting		 a. R 199's and R 145's wheelchairs were clean b. Other wheelchairs were clean inspected for cleanlines 2. <u>Corrective Action as it applies to other Resider</u> a. The facility wheelchair cleaning schedule was reviewed to assure that wheelchairs have been off cleaning schedule. 	s. <u>nts</u> : 	

Event ID: GQM312

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI			FORM A	03/21/2014 PPROVED 0938-0391 SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
		245227	B. WING	i		R-I 03/0	C 6/2014
NAME OF F	PROVIDER OR SUPPLIER	I	-	STI	REET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
BAYSHO	RE RESIDENCE & RI	EHAB CTR			01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 465}	to feed herself duri On 3/6/14, at 1:30 type wheelchair wa foot rest, the front a seat cushion and th brown and white ca had dried leaves ir was his own and n him. On 3/6/14, at 1:50 observed to have f padded arm rests At 2:00 p.m. the di observed R199's a verified they were facility had a whee were to be washed the night shift. The admitted to the fac to be washed ofter The Wheelchairs, Cleaning Schedule wheelchair was to The Nursing Assis	ng the meal. p.m. R199's electric scooter as observed to be soiled. The and back molded covering, the he arm rests were soiled with olored substances. The basket n it. R199 stated the scooter o one had offered to clean it for p.m. R145's wheelchair was food in the spokes. The black on both sides were cracked. rector of nursing (DON) and R145's wheelchairs and soiled. The DON stated the elchair washer and wheelchairs d according to a schedule on a DON stated R199 was newly cility and R145's wheelchair was		165}	 b. Initiated retraining of facility staff on wheelchair cleaning schedule. c. Checking of wheelchairs will be listed on the facility rounds sheets to validate through concurrent walking audits that the activity is occurring. 3. <u>Reoccurrence will be prevented by:</u> a. Initiated retraining of facility staff on wheelchair cleaning schedule. b. Checking of wheelchairs ha been listed on the facility rounds sheets to validate through concurrent walking audits that the activity is occurring. 4. The Correction will be monitored by: DON, Unit Managers and Designees with oversight by Nursing Home Administrator. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI committee freview. 5. Date of Completion: 3/19/1. 	n for	

Facility ID: 00589

If continuation sheet Page 22 of 22



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7999

March 24, 2014

Mr. Mike Bosley, Administrator Bayshore Residence & Rehabilitation Center 1601 Saint Louis Avenue Duluth, Minnesota 55802

RE: Project Number S5227024, H5227042, H5227044 and H5227045

Dear Mr. Bosley:

On January 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2013 that included an investigation of complaint number H5227042, and on January 31, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department's Office of Health Facility Complaints for an abbreviated standard survey, completed on January 13, 2014. The surveys found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required. As a result of finding your facility not in substantial compliance, this Department recommended to the CMS Region V Office and they concurred and authorized this Department to notify you of the following remedy for imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 19, 2014. (42 CFR 488.417 (b))

The CMS Region V Office notified your fiscal intermediary that the denial of payment for new admissions is effective March 19, 2014. They also notified the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 19, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bayshore Residence & Rehab Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective March 19, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

Bayshore Residence & Rehabilitation Center March 24, 2014 Page 2

If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

On March 6, 2014, the Minnesota Department of Health and on March 7, 2014, the Minnesota Department of Healths Office of Health Facility Complaints completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 19, 2013 and an abbreviated standard survey completed on January 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 19, 2013 and an abbreviated standard survey completed on January 13, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores F0465 -- S/S: D -- 483.70(h) -- Safe/functional/sanitary/comfortable Environ

In addition, at the time of this revisit, we identified the following deficiencies:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc) F0170 -- S/S: C -- 483.10(i)(1) -- Right To Privacy - Send/receive Unopened Mail F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

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

As a result of our finding that your facility continues to not be in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective March 29, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the following remedy will remain in effect:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 19, 2014. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective March 19, 2014.

Bayshore Residence & Rehabilitation Center March 24, 2014 Page 3

This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Patricia Halverson Minnesota Department of Health 11 East Superior Street, Suite #290 Duluth, Minnesota 55802 Phone: (218) 302-6151 Fax: (218) 723-2359 Bayshore Residence & Rehabilitation Center March 24, 2014 Page 4

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 Office of Health Facility Complaints staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Bayshore Residence & Rehabilitation Center March 24, 2014 Page 6 Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5227r14ohfc&Hlth.rtf

	-	ID HUMAN SERVICES				FORI	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	-			OMB NO	<u> 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245227	B. WING				R-C / 06/2014
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOR	E RESIDENCE & REHA	3 CTR		1	1601 ST LOUIS AVENUE		
271101101					DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 0	000}	•		
		OHFC completed an plaint number H5227047. the Intiated with one example					
	In addition, a follow u deficiencies issued su H5227042 with F333 reissued.	ubsequent to complaint					
F 157	Census 147. 483.10(b)(11) NOTIF		F	157	,		
SS=D	consult with the resid known, notify the resid or an interested famil accident involving the injury and has the pol intervention; a signific physical, mental, or p deterioration in health status in either life thr clinical complications significantly (i.e., a ne existing form of treatr consequences, or to treatment); or a decis the resident from the §483.12(a).	iately inform the resident; ent's physician; and if dent's legal representative y member when there is an resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a a, mental, or psychosocial reatening conditions or); a need to alter treatment eed to discontinue an nent due to adverse commence a new form of ion to transfer or discharge					
	and, if known, the res or interested family m	ident's legal representative ember when there is a pmmate assignment as					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

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

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		245227	B. WING				-C 06/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BAYSHOP	RE RESIDENCE & REHAB	3 CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	regulations as specific this section. The facility must reco the address and phor legal representative of This REQUIREMENT by: Based on observatio review, the facility fail and the resident's rep the change of status of residents (R171) revie and for 1 of 1 residen respiratory distress. Findings include: R171's Diagnosis Rep diagnoses including of The quarterly Minimu 1/29/14, indicated R1 required extensive as transfers and persona frequently incontinent quarterly MDS further for the development of stage 1 or greater pre admission, 2 unstage eschar present, and h devices on the chair a Assessment (CAA) da	Federal or State law or ed in paragraph (b)(1) of rd and periodically update he number of the resident's or interested family member. T is not met as evidenced n, interview and document ed to ensure the physician oresentative were notified in of a pressure ulcer for 1 of 3 ewed for pressure ulcers ts (R180) reveiwed for port dated 3/6/14, indicated erebrovascular disease. m Data Set (MDS) dated 71 was cognitively intact, sistance with bed mobility, al hygiene activities; and was to f bowel and bladder. The indicated R171 was at risk of pressure ulcers, had a essure ulcer present on able pressure ulcers, with had pressure reducing	F	157			

Facility ID: 00589

If continuation sheet Page 2 of 22

		MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
						R-C
		245227	B. WING		0;	3/06/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
BAYSHOR	E RESIDENCE & REHA	BCTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 157	Continued From page	e 2	F 1	57		
	1/13/14, indicated R1 scab measuring 1.4 c	m Identification Assessment 71's left ankle had a loose cm by 1.9 cm. and a a measuring 1.4 cm by 2.0				
Solosit Kerlix o differer R171's indicate outer a directe skin inj needeo treatme failure macera Care P	Solosite to scab, cov	rder dated 1/14/14, directed er with gauze and wrap with sess after scab comes off for				
	indicated an unstage outer ankle with 1009 directed to follow faci skin injury and to not needed, monitor/doct treatment of skin inju failure to heal signs a maceration to MD. H Care Plan dated 12/2 adhesive, wound care	ted and revised 11/8/13, able pressure ulcer on left % eschar. The Care Plan ility protocols for treatment of ify physician for orders as ument location, size, and ry, report abnormalities, and symptoms of infection, land-written notes on the 26/13, directed Allevyn [an e dressing] per MD orders.				
		ndicated R171's left ankle				
	was observed during ankle ulcer. RN-C st 3/4/14, when the sca the ulcer at 0.5 cm by clean Curad dressing covered the Curad dr gauze dressing and w	m. registered nurse (RN)-C treatment of R171's left ated the ulcer opened on b fell off. RN-C measured y 0.6 cm. RN-C applied a g to ulcer wound area, ressing with a 4 by 4 inch wrapped the ankle and I gauze dressing taping the				
	dressing with a rolled wrap in place. On 3/5/14, at 7:11 a.r					

If continuation sheet Page 3 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		245227	B. WING				R-C / 06/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BAYSHOP	RE RESIDENCE & REHA	3 CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 157	ulcer re-opened. On 3/5/14, at 11:40 a was responsible to as DON further stated w and/or the ulcer open responsible to notify t resident's family, and A Change of Condition policy reviewed and r resident's physician w timely manner either resident experiences not addressed throug protocol. The policy f	m, the DON stated RN-B seess and stage ulcers. The hen the stage changed ed up, the RN would be he resident's physician, the also the dietician. n/Special Needs Charting evised 5/2011, directed the would be contacted in a verbally or written if the a change in skin integrity, h the facility's skin care further directed the	F	157	7		
	change of condition re distress. A progress note dated indicated R180 was of her pain 10/10 in her were taken and oxyge pulse elevated to 110 (HOB) was elevated, pierce-lip breath. R1 (narcotic used for pai [the] sharp pain in [he [oxygen saturation] ro	d 2/17/14, at 6:56 p.m. calling out in pain and rated back. R180 's vital signs en saturation was 73%, r. R180 's head of bed and she was instructed to 80 also received Roxenol n) for breathing difficulties, er] back decreased as sat					

If continuation sheet Page 4 of 22

		D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/21/2014 / APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245227	B. WING					-C 06/2014
	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, ST		03/	00/2014
					601 ST LOUIS AVENUE	,		
BAYSHOR	E RESIDENCE & REHAE	3 CTR			DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	indicated that residem given 0.3 milligrams of Sulfate) per superviso self, with pursed lip br level [was] at 92%, he nebulizer just being gi resident to be on four A progress note dated Luke 's emergency ro they will be keeping re diagnosis of Carbon D diagnosis of Carbon D diagnosis of pneumor for a scheduled appoi St. Luke 's ER. R180 was admitted on that included acute ch disease (COPD). The had a focus area of al included interventions sign/symptoms of res to the MD (medical do protocol. NA-H was interviewed NA-H reported that R- times in the previous f feel good and felt fogg concerns to the LPN of complaints and the LF R180. The nurses tha LPN-A, and LPN-B. R180 was asked what day she was hospitalii was scheduled to go f the development cent arrived at the center a	4 2/18/14, at 6:08 a.m. t was in respiratory distress, of MS Sulfate (Morphine or request, resident calmed reathing, oxygen saturation eart rate was up 112 due to iven, continue to monitor, hour vital sign checks. d 2/18/14, indicated that St. bom (ER) called stating, esident overnight with Dioxide retention and new mia. Resident was sent out ntment and was referred to in 12/9/13, with diagnoses pronic obstructive pulmonary e care plan dated 12/20/13, tered respiratory status that to observed for piratory distress and report foctor) PRN (as needed) per d on 3/4/14, at 3:00 p.m. 180 had told her several two weeks that she didn ' t gy. NA-H reported these on duty at the time of the PN did go and talk with at NA-A reported to were d on 3/4/14, at 3:10 p.m. t happened on 2/18/14, the zed. R180 stated that she to a therapy appointment at er. R180 stated that she and her therapist saw her	F	157				
	and after a short time	the therapist suggested nergency room. R180						

If continuation sheet Page 5 of 22

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	IPLETED
			5.11/10			R-C
		245227	B. WING		03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOP	RE RESIDENCE & REHA	B CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	a 5	E 15	7		
1 157			F 15			
	stated that she was h	aving a lot of trouble g difficulty staying awake and				
		ist 's questions, couldn 't				
		erapist was saying and				
		e hospital. R180 was taken				
		om by the Medi-Van that had				
		e appointment. R180 stated				
		d to the Intensive Care Unit				
	with a diagnosis of a	cute exacerbation of Chronic				
		ry Disease (COPD) with				
	acute hyper-capnic re					
		d about the days leading up				
		R180 stated that she was				
		with things like dropping				
	· ·	lizer. R180 stated that she ne. R180 reported that she				
		st one week before being				
		tated that she was having				
		ing. R180 stated that she				
		ad requested to go to the				
		s but they wouldn 't send				
	her. R180 stated that	-				
		I's and they would come to				
		t nothing was done, " they				
	-	and nurses wouldn ' t				
		sked to go to the hospital.				
		was afraid because she felt				
		dy would listen. R180 stated				
	-	the hospitalization (2/17/14) d in a lot of pain, she said				
		ath, pulse was high and she				
		on that was comfortable.				
		isked LPN-A to send her to				
		A never provided her an				
	-	y R180 was not sent to the				
	hospital.					
		A was completed on 3/4/14,				
	at 3:20 p.m. LPN-A takes when a resider	was asked what steps she				

Facility ID: 00589

If continuation sheet Page 6 of 22

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · · ·	O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			IPLETED
		245227	B. WING		03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COD	E	
BAYSHOP	RE RESIDENCE & REHA	B CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 157	LPN-A stated that sh do vital signs, see if t medications that cou will call the superviso LPNA recalled an inco occurred on 2/17/14, hospitalized. R180 b complained of back p was 72% and her put contacted RN-E to re report that the reside hospital and LPN-A v RN-E stated that R18 just watch her. LPN- did stabilize however the drug seeking beh An interview of the di completed on 3/4/14, asked what the exper when a resident 's co stated that the facility complete assessmen physician, the LPN o MD 's and the LPN ' The DON expected th	e will go to the resident and they have PRN treatments or Id be tried, after that LPN-A or if there is no change. dident with R180 that the night before R180 was became short of breath, oain, her oxygen sat level les was 110. LPN-A eport the symptoms and nt is requesting to go to the would consult with the MD. 30 was drug seeking and to A reports that the resident t LPN-A didn ' t agree with avior and felt R180 was ill. irector of nursing (DON) was cat 4:30 p.m. The DON was ctation of the LPN/RN ' s are pondition changes. The DON v expects the nurse to do a	F 15	7		
	evening and night sta on duty to consult with In regards to R180's daily reports the DON happens on evenings address R180's com An interview of trained was completed on 3/ recalled an incident in	aff have a nursing supervisor th if there are any questions. s change in condition; the N receives regarding what s and night shift didn ' t				

Facility ID: 00589

If continuation sheet Page 7 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/21/2014 ORM APPROVED 3 NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING				R-C 03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER	I	I	STR	EET ADDRESS, CITY, STATE, ZIP COD)E		
BAVELO	RE RESIDENCE & REHAI	P CTP		160	1 ST LOUIS AVENUE			
DAISHON		Son		DU	LUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 157	seeking behavior and TMA-A reported that that time. Interview of RN-E was involvement with R18 evening before R180 reported that she reca situation but does not she heard about it. F the MD regarding R1 to call the MD. RN-E called. RN-E stated to to see R180 and that well. RN-E indicated notes or a log of calls supervising. RN-E do staff not to call an ME have documented in record progress notes significant event. Wh about R180 and if she indicated that she had from other staff and do information to indicated drug seeker. Interview of R180 's (MHT) was completed R180 was scheduled in the afternoon. The has been a client with years. The MHT was R180 had when she a The MHT stated that difficulties had been of three months, howeve 2/18/14. R180 was version	N-E felt R180 was drug to watch the resident. the MD was not called at s completed on 3/7/14, at asked what her 0's care on 2/17/14, the was hospitalized. RN-E alled hearing about the t recall any specifics or how N-E was asked if she called 80 or if the nursing unit was did not know if the MD that she did not go to the unit she did not know R180 that that she does not keep s she received while she is bes not recall ever telling a 0. RN-E stated she would the electronic medical s if she felt it was a teen asked further information e was a drug seeker, RN-E d heard that information lid not provide any other e a reason that R180 was a mental health therapist d on 3/18/14, at 8:30 a.m. to see her MHT on 2/18/14, e therapist stated that R180 n her for approximately five s asked what symptoms arrived to the appointment.	F	157				

If continuation sheet Page 8 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245227	B. WING				-C 06/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOP	RE RESIDENCE & REHAE	3 CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157 {F 282} SS=D	weak. R180 was hav conversation, there w questions of up to 30 dozing off during the o stated that R180 told for at least a week an worse. R180 told the her concerns to the m several times but they that she had asked to didn ' t think she need The Change in Condi Policy (revision date I The policy purpose di physician, next of kin, or significant other in change. The policy f monitor changes of co be documented. 483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by o accordance with each care. This REQUIREMENT by: Based on observation review, the facility fail directed by the plan o (R181, R171) reviewed Findings include:	ing difficulty focusing on the ere delays in responding to seconds and she was conversation. The MHT her that she has been sick d that she was getting MHT that she had reported ursing staff at the facility y didn ' t do anything and g to the hospital but they ded to go. tion/Special Needs Charting May 2011) was reviewed. rected staff to: Notify the designated contact person the event of a status further directed staff to condition and interventions to PICES BY QUALIFIED RE PLAN d or arranged by the facility qualified persons in the resident's written plan of is not met as evidenced n, interview and document	F {F 2	282]			

If continuation sheet Page 9 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245227	B. WING				-C 06/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOP	RE RESIDENCE & REHAE	3 CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	stage 2 (partial thickn presenting as shallow pressure ulcer. R181's admission Mir dated 12/20/13, indica cognitively impaired, a assist of 2 staff for be and extensive assist of MDS further indicated development of a pre- had a stage 2 pressur R181's care plan, dat was admitted with a s coccyx and directed s repositioning in bed a two hours, and as need R181 was not provide continuous observation until 12:55 p.m At 1: into bed. RN-B measu as 2.4 cm x 4 cm, and On 3/4/14, at 2:37 p.r. (DON) stated that ever minimal, some reside frequent repositioning getting worse, or if the pain. The DON furthe staff to reposition resi care plan. The facility policy and ulcers revised 5/11, d impaired skin integrity according to a standar	ess loss of dermis y open ulcer) coccyx himum Data Set (MDS) ated R181 was severely and required extensive d mobility and transfers, of one staff for toileting. The d R181 was at risk for the ssure ulcer, and currently re ulcer. ed 12/19/13, indicated R181 tage 2 pressure ulcer on the staff assistance significant nd when in wheelchair every eded. ed repositioning during on on 3/4/14, from 9:56 a.m. 01 p.m. NA-B put R181 ured R181's pressure ulcer d stated it was a stage II. n. the director of nursing ery two hours would be nts may require more g if the pressure ulcer was e resident was experiencing r stated she would expect dents as directed by their	{F 2	282)			

Facility ID: 00589

If continuation sheet Page 10 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245227	B. WING				-C 06/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOR	RE RESIDENCE & REHAE	A CTR			1601 ST LOUIS AVENUE		
DATONON		, onk			DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	further directed skin of accordance with phys staff provide skin care protocol which has be medical director and i orders. The facility policy and comprehensive care p each resident's comp designed to aid in pre in the resident's funct functional levels. R171 was not consist pressure-relieving dev ulcer; in addition the l assessed or treated a standing orders or ph The quarterly MDS da was at risk for the dev ulcers, had a stage 1	care is provided in sician's orders. The facility e according to a standard een approved by the facility's is included in the standing I procedure on plans revised 10/10, directed rehensive care plan is eventing or reducing declines ional status and/or tently provided vices for a left lateral heel eft lateral heel ulcer was not as directed by facility ysician orders. ated 1/29/14, indicated R171 velopment of pressure or greater pressure ulcer	{F 2	282			
	ulcers, with eschar pr reducing devices on t An Initial Skin Probler 1/13/14, indicated R1 have a loose scab me The Assessment also had a discolored purp by 2.0 cm. The Care Plan dated indicated R171 had a ulcer on left outer ank	m Identification Assessment 71's left ankle was noted to easuring 1.4 cm by 1.9 cm. b indicated R171's left heel ole area measuring 1.4 cm and revised 11/8/13, n unstageable pressure cle with 100% eschar that ssion to the facility with					

Facility ID: 00589

If continuation sheet Page 11 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/21/2014 / APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245227	B. WING				-C 06/2014
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOR	RE RESIDENCE & REHAE	BCTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	dressing] per MD orde directed to follow facil skin injury and to notin needed, monitor/docu treatment of skin injur failure to heal signs a maceration to MD. The directed R171 needed bilateral heel protector Physician's orders da Solosite to scab, cove Kerlix daily and reass different treatment. A Skin Ulcer Data Col form dated 2/25/14, in ulcer had healed. On 3/5/14, at 7:10 a.r was observed during R171's left ankle. The RN-C stated the left a 3/4/14, when the scat measured the ulcer at a clean Curad dressin gauze dressing and w dressing with rolled g slipper to R171's left of blue booties was lying other on the bedside observed to be resting white sock on the righ On 3/5/14, at 8:00 a.r ulcer was observed w the brown slipper sho R171's left foot/ankle.	ers. The Care Plan ity protocols for treatment of fy physician for orders as iment location, size, and y, report abnormalities, nd symptoms of infection, he Care Plan further d assistance to apply rs. ted 1/14/14, directed er with gauze and wrap with ess after scab comes off for llection and Assessment ndicated R171's left ankle n. registered nurse (RN)-C a dressing change to e dressing was removed and inkle ulcer had reopened on o had fallen off. RN-C t 0.5 cm by 0.6 cm., applied ng, added a 4 by 4 inch vrapped the ankle and auze. RN-C applied a brown foot. One of R171's quilted g on the dresser and the table. R171's right heel was g on the bed with only a tt foot.	{F 2	282)			

Facility ID: 00589

If continuation sheet Page 12 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		245227	B. WING				06/2014
NAME OF P	ROVIDER OR SUPPLIER				BTREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BAYSHOP	RE RESIDENCE & REHAR	3 CTR		0	DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	ankle ulcer was stage physician and family of pressure ulcer reoper she changed R171's vaseline dressing dail not apply R171's left II On 3/5/14, at 9:45 a.r interviewed. RN-B sta standing orders for we stated when R171's h re-opened, she decid based on her wound of further stated she doe nurse practitioner or t of orders when an ulce R171's ulcer treatmer vaseline-type dressin not notified of the cha and there was no phy treatment. On 3/5/14, at approxin observed seated in w nurses' station wearing brown slipper shoes. On 3/5/14, at 11:40 an re-interviewed and sta assess and stage ulce when the stage change up, the RN would be resident's physician, t also the dietician. Th expect the ulcers to b weekly and the result weekly skin sheet or i	-B stated the left lateral e 2. RN-B confirmed the were not notified when the ned on 3/4/14. RN-B stated ulcer treatment to a ly with dry gauze. RN-B did blue-quilted heel boot. In the DON and RN-B were ated she was unaware of any bound care. RN-B further nealed left lateral ankle ulcer ed on a different treatment care experience. RN-B es not usually contact the he physician with a change ser opens up. RN-B verified int was changed to a g and R171's physician was inge in condition of the ulcer risician's order to change the mately 10:45 a.m. R171 was heelchair in hallway near ing white stockings and	{F 2	282}			

If continuation sheet Page 13 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				INTED: 03/21/2014 FORM APPROVED IB NO. 0938-0391	
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	INSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING	 	R-C 03/06/2014		
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	Ē		
BAYSHOP	RE RESIDENCE & REHAI	3 CTR		 ST LOUIS AVENUE UTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 282} {F 314} SS=D	protocol to cover ulce stated R171's left late stage 2 when the sca confirmed she was no ulcer opening up until 483.25(c) TREATMEI PREVENT/HEAL PRI Based on the compre- resident, the facility m who enters the facility m who enters the facility m who enters the facility m does not develop pre- individual's clinical co- they were unavoidabl pressure sores receiv services to promote h prevent new sores fro This REQUIREMENT by: Based on observatio review, the facility fail care of pressure ulce R171) reviewed for pre- Findings include: Pressure Ulcer Stage Pressure Ulcer Advise Stage I: Non-blancha Intact skin with non-b localized area usually The area may be pair cooler as compared to Stage II: Partial thickness loss	er care changes. The DON eral ankle ulcer would be b/eschar fell off. The DON of made aware of R171's I this morning. NT/SVCS TO ESSURE SORES whensive assessment of a nust ensure that a resident y without pressure sores ssure sores unless the ondition demonstrates that le; and a resident having yes necessary treatment and healing, prevent infection and om developing. - is not met as evidenced n, interview and document led to provide appropriate rs for 2 of 3 residents (R181, ressure ulcers. es (defined by the National ory Panel) ble erythema lanchable redness of a y over a bony prominence. nful, firm, soft, warmer or o adjacent tissue.	{F 3				

If continuation sheet Page 14 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/21/2014 MAPPROVED O. 0938-0391	
STATEMENT (CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING			R-C 03/06/2014		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BAYSHOR	E RESIDENCE & REHA	3 CTR			601 ST LOUIS AVENUE			
					DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
{F 314}	without slough. May a	e 14 also present as an intact or -filled or sero-sanginous	{F :	314}				
	filled blister. Presents ulcer without slough o Unstageable/Unclass	as a shiny or dry shallow or bruising. ified: Full thickness skin or						
	the ulcer is completel	oss in which actual depth of y obscured by slough						
	(tan, brown or black) enough slough and/o	en or brown) and/or eschar in the wound bed. Until r eschar are removed to						
	cannot be determined	e wound, the true depth J.						
	R181 was not provide stage 2 coccyx press	ed timely repositioning for a ure ulcer.						
	Alzheimer's disease, osteoporosis. The ad	ord indicated diagnosis of generalized pain and mission Minimum Data Set 3, indicated R181 was						
	severely cognitively in extensive assist of 2 transfers, and extens	npaired, and required staff for bed mobility and ive assist of one staff for						
	-	rther indicated R181 was at ent of a pressure ulcer, and 2 pressure ulcer.						
	was admitted with a s	ed 12/19/13, indicated R181 stage 2 pressure ulcer on the staff assistance significant						
	repositioning in bed a two hours, and as ne assistant group sheet	nd when in wheelchair every eded. Although the nursing directed staff to check and						
	offer toileting every tw repositioning was not	vo hours and as needed, addressed.						
		ly observed on 3/4/14, from p.m R181 was observed in						

Facility ID: 00589

If continuation sheet Page 15 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/21/2014 ORM APPROVED 3 NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		245227	B. WING				R-C 03/06/2014
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STR	EET ADDRESS, CITY, STATE, ZIP COD	E	
BAYSHOR	RE RESIDENCE & REHAI	B CTR			1 ST LOUIS AVENUE LUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
{F 314}	until 10:22 a.m. R181 activity room and and 11:40 a.m. R181 was and finished feeding 1 12:52 p.m., R181 had without repositioning Registered nurse (RN (NA)-B were informed repositioning and R12 bedroom at 12:54, p., the way to the dining R181 required every 1:01 p.m. NA-B put measured R181's pre cm, and stated it was On 3/4/14, at 2:37 p.t (DON) and RN-B wer she directed all depe every two hour repos stated that every two some residents may repositioning if the pr worse, or if the reside The DON further stat reposition residents a The facility policy and ulcers revised 5/11, o impaired skin integrity according to a standard standards of practice further directed skin car protocol which has be	ed by staff from 10:10 a.m. was brought back into the then to the dining room at served lunch at 12:11 p.m., herself at 12:49 p.m. At d been in the wheelchair for 2 hours and 30 minutes. N)-B and nursing assistant d of R181's lack of 81 was wheeled to the m NA-B stated she was on room to get R181 and knew two hour repositioning. At R181 into bed. RN-B essure ulcer as 2.4 cm x 4 a stage 2. m. the director of nursing re interviewed. RN-B stated ndent residents to have an itioning plan. The DON hours would be minimal, require more frequent essure ulcer was getting ent was experiencing pain. ed she would expect staff to as directed by their care plan. d procedure on pressure lirected residents with y receive treatment ard protocol that meets . The policy and procedure	{F :	314}			

If continuation sheet Page 16 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/21/2014 M APPROVED D. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING				R-C /06/2014	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
BAYSHOP	RE RESIDENCE & REHAI	B CTR			601 ST LOUIS AVENUE			
					DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 314}	Continued From page	e 16	{F :	314}				
	ulcer; in addition the l assessed or treated a standing orders or ph A Diagnosis Report d R171's diagnoses inc disease. The quarterly MDS da was cognitively intact assistance with bed r personal hygiene actii incontinent of bowel a MDS further indicated development of press greater pressure ulce unstageable pressure and had pressure red and bed. A Care Are 11/4/13, indicated R1 ulcers and the left an CAA further indicated included pressure wit special mattress or se relieve pressure and of turning. An Initial Skin Probler 1/13/14, indicated R1 bruise. The Assessm left ankle was noted t measuring 1.4 cm by	vices for a left lateral heel left lateral heel ulcer was not as directed by facility sysician orders. lated 3/6/14, indicated cluded cerebrovascular ated 1/29/14, indicated R171 c, required extensive nobility, transfers and ivities, and was frequently and bladder. The quarterly d R171 was at risk for the sure ulcers, had a stage 1 or er present on admission, 2 e ulcers, with eschar present, lucing devices on the chair a Assessment (CAA) dated 71 was at risk for pressure kle bone had a scab. The I R171's extrinsic risk factor th interventions of needing a eat cushion to reduce or requiring a regular schedule m Identification Assessment 71 had an ulcer and a nent further indicated R171's to have a loose scab 1.9 cm. The Assessment a left heel had a discolored						
	R171's Care Plan dat	ted and revised 11/8/13,						
							_	

Facility ID: 00589

If continuation sheet Page 17 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED 8 NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) [DATE SURVEY COMPLETED
		245227	B. WING				R-C 03/06/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BAYSHOR	RE RESIDENCE & REHAE	3 CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 314}	indicated actual impai related to an abrasior elbow, left hip, scabbe and several scabs to ankle. The Care Plan indicated R171 had a ulcer on left outer ank was present on admis treatment of Allevyn [i dressing] per MD orded directed to follow facil skin injury and to noti needed, monitor/docu treatment of skin injur failure to heal signs a maceration to MD. The directed R171 needed bilateral heel protector The undated nursing directed R171 was to heel/foot at all times. A Patient Information dated 1/14/14, indicated measuring 1.4 cm by off on left ankle. The indicated the nurse w receive orders to app with gauze and wrap reassess after scab c treatment. A Skin Ulcer Data Col form dated 2/25/14, indicated was closed, with som	irment to skin integrity n to the left outer leg, left ed areas to the left knee, lower legs and left outer n note dated 12/26/13, n unstageable pressure de with 100% eschar that ssion to the facility with adhesive wound care ers. The Care Plan lity protocols for treatment of fy physician for orders as ument location, size, and ry, report abnormalities, nd symptoms of infection, he Care Plan further d assistance to apply ors. assistant assignment sheet have the blue boot on left Fax for order requested ted R171 had a thick scab 1.9 cm, loose and coming order requested fax further as requesting and did ly Solosite to scab, cover with Kerlix daily and	{F 3	314}	}		

Facility ID: 00589

If continuation sheet Page 18 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/21/2014 ORM APPROVED NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION	(X3) [DATE SURVEY COMPLETED	
		245227	B. WING			R-C 03/06/2014		
NAME OF PI	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
BAYSHOR	RE RESIDENCE & REHAI	3 CTR			1 ST LOUIS AVENUE LUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 314}	pain The progress n area would be left op note further described discolored area meas which was blanchabl On 3/5/14, at 7:10 a.r was observed during R171's left ankle. The RN-C stated the left a 3/4/14, when the scal stated R171's left late unstageable with a re drainage on the old d the ulcer at 0.5 cm by Curad dressing, adde dressing and wrapper with rolled gauze. RN to R171's left foot. O booties was lying on the bedside table. R observed to be restin white sock on the righ On 3/5/14, at 7:11 a.r lateral ankle ulcer wa further stated she ass when the ulcer re-ope or report the change. was to wear the quilte bed. RN-B stated R area was another pre- ulcer. On 3/5/14, at 8:00 a.r ulcer was observed w the brown slipper sho R171's left foot/ankle	ote further indicated the en to the air. The progress d R171's left heel with a suring 1.7 cm by 2.0 cm, e and non-painful. m. registered nurse (RN)-C a dressing change to e dressing was removed and ankle ulcer had reopened on to had fallen off. RN-C eral ankle ulcer was eddened wound bed and no ressing. RN-C measured to 0.6 cm., applied a clean ed a 4 by 4 inch gauze d the ankle and dressing l-C applied a brown slipper ne of R171's quilted blue the dresser and the other on 171's right heel was g on the bed with only a	{F :	314}				

Facility ID: 00589

If continuation sheet Page 19 of 22

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/21/2014 RM APPROVED IO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT CON	TE SURVEY MPLETED	
		245227	B. WING		R-C 03/06/2014		
	ROVIDER OR SUPPLIER	BCTR		STREET ADDRESS, CITY, STATE, ZIP COI 1601 ST LOUIS AVENUE DULUTH, MN 55802	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 314}	and gauze wrap. RN ankle ulcer was stage physician and family pressure ulcer reoper she changed R171's vaseline dressing dai not apply R171's left On 3/5/14, at 9:45 a.r interviewed. RN-B sta standing orders for w stated when R171's h re-opened, she decid based on her wound further stated she doo nurse practitioner or fo of orders when an ulc R171's ulcer treatme vaseline-type dressin not notified of the cha and there was no phy treatment. On 3/5/14, at approxi observed seated in w nurses' station wearin brown slipper shoes. On 3/5/14, at 11:40 a re-interviewed and st assess and stage ulc when the stage chan up, the RN would be resident's physician, also the dietician. Th expect the ulcers to to weekly and the result weekly skin sheet or	-B stated the left lateral e 2. RN-B confirmed the were not notified when the ned on 3/4/14. RN-B stated ulcer treatment to a ly with dry gauze. RN-B did blue-quilted heel boot. m. the DON and RN-B were ated she was unaware of any ound care. RN-B further nealed left lateral ankle ulcer led on a different treatment care experience. RN-B es not usually contact the the physician with a change cer opens up. RN-B verified nt was changed to a g and R171's physician was ange in condition of the ulcer vsician's order to change the mately 10:45 a.m. R171 was theelchair in hallway near ng white stockings and	{F 31	4}			

If continuation sheet Page 20 of 22

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245227	B. WING	 		-C 06/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOR	E RESIDENCE & REHAE	3 CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 314} {F 465} SS=D	stated R171's left late stage 2 when the sca confirmed she was no ulcer opening up until On 3/5/14, at 12:05 p computer print out of indications for use. T heel pillows provided breakdown, heel decu shearing and/or skin f the heel pillow's manu- information describing relieving or reducing. 483.70(h) SAFE/FUNCTIONAL/ E ENVIRON The facility must prov sanitary, and comforta residents, staff and th This REQUIREMENT by: Based on observation review the facility did were kept clean for 2 residents. Findings include: On 3/3/14, at 5:22 p.r observed in the secon- wheelchair had multip frame, foot rests, and	r care changes. The DON bral ankle ulcer would be b/eschar fell off. The DON of made aware of R171's this morning. .m. the DON provided a the DeRoyal Heel Pillows he print out indicated the protection against skin ubitus ulcer prevention, skin friction. The DON confirmed ufacturer's indications lacked g the product as pressure (SANITARY/COMFORTABL) ide a safe, functional, able environment for e public. f is not met as evidenced in, interview and document not ensure wheelchairs of 3 (R199, R145) 	{F 3	}		

If continuation sheet Page 21 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R-C	
		245227	B. WING			03/06/2014	
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOP	RE RESIDENCE & REHAE	3 CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 465}	to feed herself during On 3/6/14, at 1:30 p.r type wheelchair was of foot rest, the front and seat cushion and the brown and white color had dried leaves in it. was his own and no of him. On 3/6/14, at 1:50 p.r observed to have food padded arm rests on At 2:00 p.m. the direct observed R199's and verified they were soil facility had a wheelch were to be washed act the night shift. The Do admitted to the facility to be washed often. The Wheelchairs, Wa Cleaning Schedule (n wheelchair was to be The Nursing Assistan	the meal. n. R199's electric scooter observed to be soiled. The d back molded covering, the arm rests were soiled with red substances. The basket R199 stated the scooter one had offered to clean it for m. R145's wheelchair was d in the spokes. The black both sides were cracked. etor of nursing (DON) R145's wheelchairs and led. The DON stated the air washer and wheelchairs ccording to a schedule on ON stated R199 was newly y and R145's wheelchair was	{F 4	465}			

If continuation sheet Page 22 of 22



Protecting, Maintaining and Improving the Health of Minnesotans

March 22, 2013

Mr. Mike Bosley, Administrator Bayshore Residence & Rehabilitation Center 1601 Saint Louis Avenue Duluth, Minnesota 55802

Re: Enclosed Reinspection Results - Complaint Number H5227044 and H5227045

Dear Mr. Bosley:

On March 7, 2014 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on January 13, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00589	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/7/2014
Name of Facility			Street Address, City, State, Zip Code	
BAYSHORE RESIDENCE & REHAB CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix	20830	Correction Completed 01/28/2014	ID Prefix	21545	Correction Completed 01/28/2014	ID Prefix			Correction Completed
Reg. #	MN Rule 4658.0520 Subp.	1		MN Rule 4658.1320 A.B.C		Reg. #			
LSC		-	LSC		-	LSC			_
ID Prefix Reg. # LSC			Reg. #			Reg. #			Correction Completed
Reg. #			Reg. #			Reg. #			
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		_	ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Correction Completed
Reviewed By		•	Date: 03/24/20	Signature of Surve	eyor: 3595			Date: 03/0	7/2014
Reviewed By			Date:	Signature of Surve				Date:	,,2011
CMS RO Followup to Survey Completed on: 1/13/2014 STATE FORM: REVISIT REPORT (5/99)			 	-		Deficiencies. Was s (CMS-2567) Sent	to the Facility?	YES 16GZ12	NO

DEPARTMENT OF HE	CALTH AND HUMA	AN SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES		
	MEDICA	ARE/MEDICAII	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: GQM3		
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00589		
 MEDICARE/MEDICAID PRODUCIES (L1) 245227 STATE VENDOR OR MEDICIES (L2) 1821433426 	3. NAME AND ADDRESS OF FACILITY (L3) BAYSHORE RESIDENCE & REHA (L4) 1601 ST LOUIS AVENUE		L6) 55802	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint				
	(L5) DULUTH, MN			7. On-Site Visit 9. Other				
5. EFFECTIVE DATE CHANG (L9) 07/01/2013	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint				
8. ACCREDITATION STATUS 0 Unaccredited 1 7	REDITATION STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC ccredited 1 TJC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE			D 15 ASC	FISCAL YEAR ENDING DATE: (L35) 12/31			
11LTC PERIOD OF CERTIFIC	CATION	10.THE FACILITY	Y IS CERTIFIED	AS:		·		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit		
12.Total Facility Beds	Compliance Based On: 1. Acceptable POC			3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size				
13.Total Certified Beds	140 (L17)	X B. Not in Con Baguiram	npliance with Prog ents and/or Appli		5. Life Safety Code * Code: B *	9. Beds/Room (L12)		
14. LTC CERTIFIED BED BRE	AKDOWN	Kequitein		leu warvers.	15. FACILITY MEETS	(L12)		
			IID			(L15)		
18 SNF 18/19 14		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(113)		
(L37) (L3	38) (L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY See Attached Remarks	Y REMARKS (IF APPLIC	ABLE SHOW LTC C	CANCELLATION	NDATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL Date:		
Teresa Ament,	HFE NEII	0	01/29/2014	(L19)		(L20)		
-	PART II - TO BE	COMPLETED B	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF EL 1. Facility is Eligit		IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :			
2. Facility is not E	Eligible (L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION 01/22/1979	BEGINNING	G DATE	ENDING DA'	TE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNAT	IVE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L2	7) B. Rescind S	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	9. INTERMEDIARY	/CARRIER NO.		30. REMARKS			
		52280						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	9 32	2. DETERMINATION	N OF APPROVAL	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: GQM3 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00589

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5227

On December 19, 2013 a standard survey was completed at this facility. The most serious was widespread deficiencies that constituted no actual harm with potential for more than, cited at a S/S level of F. The standard survey also involved a complaint investigation of complaint number H5227042.

On January 13, 2014, an abbreviated standard survey was completed at this facility, involving complaint numbers H5227044 and H5227045. The most serious was isolated deficiencies in your facility to be isolated deficiencies that constitute actual harm that was not immediate jeopardy, cited at a S/S level of G.

As a result of the survey findings, this department recommended and the CMS Region V Office concurs and had authorized this department to notify the facility of the imposition:

Mandatory Denial of Payment for new Medicare and Medicaid admissions, effective March 19, 2014

Refer to the CMS 2567 for both teh standard and abbreviated standard surveys for results of the surveys.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7869

January 15, 2014

Mr. Mike Bosley, Administrator Bayshore Residence & Rehabilitation Center 1601 St Louis Avenue Duluth, Minnesota 55802

RE: Project Number S5227024, H5227042

Dear Mr. Bosley:

On December 19, 2013, a standard survey was completed at your facility by the Minnesota Departments 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. In addition, at the time of the December 19, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5227042.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 19, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5227042 that was found to be substantiated at F333 and F314.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

> <u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor Minnesota Department of Health 11 East Superior Street, Suite #290 Duluth, Minnesota 55802

Phone: (218) 302-6151

Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 28, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 28, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 19, 2014 (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). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5227s14.rtf

JENTE	RS FOR MEDICARE	AND HUMAN SERVICES	5 5		RINTED: 01/1 FORMAPPE MB NO: 0938	ROVE
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY
		245227	B. WING	IAN 2 7 2014	12/19/20)13
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/10/20	
· · · · · · · · · · · · · · · · · · ·	ORE RESIDENCE & RE		16 D	501 ST LOUIS 地 色和したHealth Duluth ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ОВЕ СОМ	(X5) PLETIOI DATE
F 000	INITIAL COMMENT	rs	F 000			
	WILL SERVE AS Y COMPLIANCE UP ACCEPTANCE. YC			OK New 520 1-29-14 1-29-14		
	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL COI REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION.				
F 162 SS=D	completed. The cor deficiencies issued 483.10(c)(8) LIMITA PERSONAL FUNDS The facility may not personal funds of a services for which p Medicaid or Medicar deductible and coins facility may charge t services that are mo excess of covered s §489.32 of this chap (This does not affect charges for items an Medicaid has paid.	impose a charge against the resident for any item or ayment is made under re (except for applicable surance amounts). The he resident for requested ore expensive than or in ervices in accordance with ter.	F 162	Disclaimer: Preparation and/or execution of this plan of correct does not constitute admissions agreements by the provider of truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because is provided by the provisions of Federal and State Law. Bay Shore Residence and Rehabilitation Center strives to provide a safe and pleasant environment for all residents, visitors, and staff members.	tion or the e it	
ORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	TITLE	(X6) DAT	Ē
IKKO	Bade			n may be excused from correcting providing	Jacobs	2

program participation.

Martin and a state of the state

		AND HUMAN SERVICES & MEDICAID SERVICES	-			FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245227	B. WING	i		12/	19/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR			601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 162	plus any deductible required by the plan During the course of Medicaid stay, facili for the following cat Nursing services as subpart. Dietary services as subpart. An activities progra this subpart. Room/bed maintent Routine personal hy required to meet the including, but not lin comb, brush, bath s specialized cleansin treat special skin pr razor, shaving creat denture adhesive, of moisturizing lotion, swabs, deodorant, supplies, sanitary n towels, washcloths, counter drugs, hair bathing, and basic Medically-related so §483.15(g) of this se Listed below are ge examples of items a may charge to resid reguested by a resi resident that there	ment in full, Medicaid payment , coinsurance, or copayment to be paid by the individual.) of a covered Medicare or ties may not charge a resident regories of items and services: a required at §483.30 of this required at §483.35 of this m as required at §483.15(f) of ance services. ygiene items and services as e needs of residents, nited to, hair hygiene supplies, soap, disinfecting soaps or ng agents when indicated to oblems or to fight infection, m, toothbrush, toothpaste, denture cleaner, dental floss, tissues, cotton balls, cotton incontinence care and apkins and related supplies, hospital gowns, over the and nail hygiene services, personal laundry. becal services as required at subpart.	F	162	 <u>F 162</u> <u>Corrective Action:</u> The facility will provide information on covered and non-covered Medicaid cost upon admission. <u>Corrective Action as it applit</u> to other residents: Medicaid residents will rece a copy of the policy regardi services or items covered under the Medicaid contract <u>Reoccurrence will be</u> <u>prevented by:</u> Newly admitted residents v receive a copy of the service or items covered under the Medicaid contract upon admission to the facility. <u>The Correction will be</u> <u>monitored by:</u> Social Services and Business Office <u>Date of Completion: 1/28/s</u> 	s ies eive ng ct ct vill es	
		le by Medicare or Medicaid:					

Facility ID: 00589

If continuation sheet Page 2 of 52

	ALTH AND HUMAN SERVICES ARE & MEDICAID SERVICES			APPROVED 0938-0391
ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY
	245227	B, WING	12/	19/2013
	LIER		ENUE BO2 ER'S PLAN OF CORRECTION	. (X5)
PREFIX (EACH DEFI	CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)		RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
Personal com materials, not Cosmetic and excess of tho Medicaid or M Personal cloth Personal read Gifts purchas Flowers and p Social events the scope of t under §483.1 Noncovered s privately hired Private room, required (for control). Specially pre instead of the facility, as red The facility m her represen requested by require a res request any i admission or inform the re requesting al will be made item or servin	io for personal use. fort items, including smoking ions and novelties, and confec grooming items and services se for which payment is made ledicare. hing. ling matter. ed on behalf of a resident.	sted e r.t. is or of under sted e r.t. is or of ive) to of ust tive) to of ust tive) to	a to #4. admission packet financial file, eck that copy of place. Results will ted to the Quality committe to assess by compliance. 1/20/ TS	1
Ваsed оп in facility failed	terview and document review, to provide 1 of 1 family membe nation οπ covered and non-co	ers		
> IRM CMS-2567(02-99) Previous		ID: GQM311 Facility ID: 00589	If continuation she	eet Page 3 of 52

:

۰.

. . .

.......

·

••

.. : Ŀ.

· · · · · · · · · · · ·

.

	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMF	SURVEY >LETED
		245227	B. WING			12/1	9/2013
	ROVIDER OR SUPPLIER RE RESIDENCE & R			1601	ET ADDRESS, CITY, STATE, ZIP CODE ST LOUIS AVENUE LUTH, MN 55802		
AYSHOI (X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	. ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 162	Continued From p Medicaid costs.	age 3	F	162	F 170		•
	Findings include: On 12/19/13 at 11	:16 a.m., FM-1 was interviewed list of services and items that charged for was not provided n process.			 <u>Corrective Action:</u> Residents will receive the personal mail on Saturda <u>Corrective Action as it ap</u> <u>to other residents:</u> Residents will receive per 	y s. <u>plies</u> rsonal	
•	hung interviewed	2:25 p.m., social worker (SW)-F and verified the lack of evidence formation was provided to FM-1.			mail delivery on Saturday 3. <u>Reoccurrence will be</u> <u>prevented by:</u> Activity staff and Social Services staff have been		
	The facility was uprocedure regard covered under N	unable to provide a policy and ding services or items not ledicaid.			orientated to the "Mail f and will ensure appropri delivery to the nursing u every Saturday.	ate	
F 17 SS=0		UNOPENED MAIL	F	- 170	4. <u>The Correction will be</u> <u>monitored by:</u> Activities and Social Ser		
· -	I communications	s the right to privacy in written , including the right to send and e mail that is unopened.			5. <u>Date of Completion: 1/</u> Addendum to # 4. Week staff to be assigned to	rud nu	
2	by: Based on inter facility failed to their personal f	MENT is not met as evidenced view and document review the ensure that residents received nail on Saturdays. This deficient e potential to effect all 126 e facility.	-		that Saturday mail deliver S:00pm with restillts m to activities an social s will be reporteded to the committee to assess f romoliance - 1/28/1	eported ervices Quality or On <u>4 J3</u>	Restuty Hssimane

•

. -.

. ..

......

-Jan.28.2014 6:0(

.

۱ ...:

		- WIMAN SERVICES			FORM APPRO OMB NO. 093B-	0391
ARTM	IENT OF HEALTH	AND HUMAN SERVICES			(X3) DATE SURV COMPLETE	EY
NTERS	FOR MEDICARE	C INC. STOPPIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	CUMPLETE.	l l
	E NEFICIENCIES	(X1) PROVIDENSOT LIB IDENTIFICATION NUMBER:	A BUILDING	·	12/19/20	12
LAN OF	CORRECTION		B. WING			13
		245227		TREET ADDRESS, CITY, STAT	E, ZIP CODE	
	A HAR OR SUPPLIES	1	1	601 ST LOUIS AVENUE		
NE OF PF	ROVIDER OR SUPPLIEF	THERCTR	lτ	NUTH MN 55802		(X5)
YSHOF	RE RESIDENCE & F	REHABUTK		PROVIDER'S PLA		DATE
	SI MMMARY S	TATEMENT OF DEFICIENCIES	PREFIX TAG		TO THE APPROPRIATE	
(4) ID REF1X	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL CLSC IDENTIFYING INFORMATION)		DEFIC	Cherry Market Laborat	· ·
TAG	REGULATOR			FITO Addendum to	resident council age this. TS 1/28/14	inde
			F 17			
F 170	Continued From	page 4		40 GISCON		
F 170	CONLINES			<u>F 282</u>		
				1. Corrective	Action:	
	Findings include			The facility	will provide care as	
-				directed b	v the plan of care	1
	During an inten	view on 12/17/13, at 12:30 p.m. uncil president (R49) asked if		specific to	ADL's, incontinence,	
	the resident cu	union proceed timety R49 stated		renosition	ing, and Isolation	
	I resident mail w	as using any		procoutio	ns.	
	"Looking at the	ba a week hefore I get it." R49	ł	. piecoular	fingernails have been	
				d.j (CSS)	ed and trimmed.	
	Monday-Satur	day by 5 p.m	l	L P 12	5 has expired.	`
				0.1 1 23	and R 39 care plan	
	- Suite di	irector (AD) was interviewed on		C.) N 23	group sheets will be	
	1 10147113 251	COU D.111. 0110	SK	anu	ewed and revised as	1
	staff delivere	d the mail.	ł	Tevic	ded for appropriate	1
				nee	ositioning and	
		s office manager (BO)-A, intervie	∋wed	rep	ontinence care.	
1	The busines	at 1:39 p.m., stated the mail wa	IS DV	inco	08 will have the care	4
	delivered to	at 1:39 p.m., stated the mail the facility Monday through Frida alk staff sorted the mail by units	ay. and	d.) R 1	Us will have the cito	
) The front de	SK Stati Social unit Nursing S	stan	pla	n and group sheets	
1	R4 delivered	the mail to individ	iuai	rev	viewed and revised as	
	was respon	Sille to define that even if IT	nall	ne	eded for appropriate	
	residents. L	O-A further stated that over the ed on Saturdays there was no fr		re	positioning.	1.
	desk staff b	o accept it.		e.) R	34 care plan will be	
				1	viewed for appropriate	
1			_	ls	olation	
	0- 10/18/	13 at approximately 1:00 p.m. R-		P	rocedures/Precautions. R	
	verified ma	13 at approximately 1.00 p.m. and all was not delivered to the facility because the "Office is closed."	Lý Oli	3	4's chart and medical	
	Saturdays	ail was not delivered to the because the, "Office is closed."		ļ г	ecord was reviewed by	
	1				DON, Nurse Practioner,	ł
		dent Mail Delivery policy, last up indicated that when the mail is	dated		and Physician. It was	1
	1 ne Kesi 12/17/13	indicated that when the mail is	arate the		If continuation s	sheet Page
	delivered	on Saturda a state	ent ID: GQN7311	Facility ID: 00589	IT CONTINUATION .	
	RM CMS-2567(02-99) Pre	evious Versions Obsolete Eve				
: 50					f	
• •	• ·					
:						
				•		
· . i						
	•					

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES		CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
ID PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·		
		245227			12	/19/2013
AME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & R	EHAB CTR		01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 170	Continued From pa	age 5	F 170			
•	•	the business mail and	-			
		d be delivered to the		determined that no		
F 282	appropriate nursing	g units. RVICES BY QUALIFIED	F 282	medical necessity wa	S	
	PERSONS/PER C		1 202	found for continued		
				isolation. Isolation h		
	The services provided by must be provided by	ded or arranged by the facility by qualified persons in		been discontinued.	ine	
	accordance with e	ach resident's written plan of		COTA has been re- educated on contact	and	
	care.			droplet isolation	anu	
				precautions.		
	This REQUIREME	NT is not met as evidenced		2. <u>Corrective Action as it ap</u>	plies	
•	by:	tion interview and decumant		to other residents:		
		Based on observation, interview and document review, the facility failed to provide care as		a. The facility will		
	directed by the pla	n of care for 1 of 3 residents		develop a policy	for	
		r activities of daily living (ADLs); 23, R39) reviewed for	-	diabetic nail care		
		4 residents (R23, R39, R108,		100% audit of all		
	R125) reviewed fo	r pressure ulcers and 1 of 1		residents to ensu	ire	
	residents (R34) in	isolation precautions.		nail care is comp	leted	
				per plan of care.		
	Findings include:			b. 100% audit of re		
				care plans and g	•	
	R33 was observed	d, on 12/16/13, at 4:47 p.m. to		sheets whom rec	•	
	have long, untrimr	ned fingernails with debris		repositioning and incontinence car	•	
	under the nails.			ensure that	eto	
				appropriate		
		ncluded diabetes, glaucoma		interventions are	e in	
		. The admission Minimum Data 9/4/13, indicated R44 required		place.		
	extensive assistar	nce of one staff for personal		c. There are curren	tly no	
	hygiene (including	nail care). R33's nail care was		residents on Isol	-	
	provided by licens	ed nursing staff due to the		Precautions.		

1944 - 1 - A

.

		AND HUMAN SERVICES			-	FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY
		245227	B. WING			12/1	19/2013
NAME OF F	PROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR			601 ST LOUIS AVENUE		
				D	ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	Continued From pa diagnosis of diabet	-	F 2	282			
•					3. <u>Reoccurrence will be</u>		
					prevented by:		
		39 p.m., registered nurse			a. Nursing staff in		
		ewed and stated licensed			serviced to revised	l nail	
		blete nail care on diabetic 9/13, at 2:28 p.m. the director			care policy.		
		rerified diabetic nail care is to			b. All residents' nails		
	be done by license	d staff.			be checked that th	•	
	The facility was up	able to provide a policy and			are clean and trim		
	procedure on diabe				weekly x 1 month monthly x 2 per th		
					plan of care. Resu		
	R125 was not repo	sitioned as directed in the care			will be reported to		
	plan.				Quality Assurance	the	
					Committee to asse		
		included dementia, chronic generalized weakness, and			for ongoing		
		derate degree. The significant			compliance.		
		Data Set (MDS) dated			c. Nursing staff		
		I R125 had moderately skills and required extensive			inserviced on		
		d mobility and transfers,			repositioning and		
		ge I pressure ulcer and was on			incontinence care.		
	a turning and report	sitioning schedule.			d. Daily audits x 1 we	ek	
					and then 2 x week	x 2	
		pdated 11/27/13, indicated a			months to assure		
		ulcer to the left hip, and			repositioning and/	or	
	directed staff to rec repositioning, chec	ck feet and heel and other bony			incontinence care		
	prominence during	repositioning, and to			completed per car		
		very one and one half hours			plan. Results will b		
		ance with position changes.			reported to the Qu		
					Assurance Commit		
	On 12/18/13, from	7:25 a.m. through 10:05 a.m.			to assess for ongoi		
FORM CMS-2	567(02-99) Previous Version	is Obsolete Event ID: GQM3	511	Fa	cility ID: 00589 If continu	ation shee	t Page 7 of 52

¢

SERVICES SERVICES				FORM A	01/14/2014 .PPROVED .)938-0391
SUPPLIER/CLIA (X2	•			(X3) DATE COMP	
5227 B.	WING			12/1	9/2013
		160	01 ST LOUIS AVENUE	•	
CIENCIES EDED BY FULL NFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
n the wheelchair. nd propelled his e dining room to the unit. At d staff approach not reposition as interviewed on .m. The DON follow the care edule. on skin 11, directs care d with interventions and providing an	F 2	282	updated of any resident on isolatio precautions to inc reason for isolatio and type of isolatio needed. 4. <u>The Correction will be</u> <u>monitored by:</u> DON, Unit Manager, and designees with oversight b Nursing Home Administra	on lude n on on by	
ing as directed by g reviewed ktensive y two hours when at 4:30 a.m. to this time nursing er left side with a continually her room, until ne on (3 hours,					
	SERVICES SUPPLIER/CLIA ION NUMBER: 4. 5227 B. CIENCIES DED BY FULL NFORMATION) A the wheelchair. A the propelled his e dining room A to the unit. At A the wheelchair. A the the wheelchair. A the wheelchair. A the	SERVICES SUPPLIER/CLIA ION NUMBER: (X2) MUL A. BUILD 4.5227 B. WING CIENCIES EDED BY FULL NFORMATION) ID PREFINATION An the wheelchair. Ind propelled his e dining room a to the unit. At d staff approach not reposition F 2 As interviewed on .m. The DON ollow the care edule. F 2 On skin [1], directs care d with interventions and providing an F 3 Ing as directed by g reviewed dtensive y two hours when F 4:30 a.m. to this time nursing er left side with a continually her room, until	SERVICES SUPPLIER/CLIA ION NUMBER: A. BUILDING_ 5227 B. WING 5227 B. WING 5227 B. WING 571 164 DL CIENCIES DED BY FULL NFORMATION) A the wheelchair. TAG TAG F 282 A the wheelchair. TAG F 282 A t	SERVICES O SUPPLER/CLA TON NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) MULTIPLE CONSTRUCTION A BUILDING 5227 B. WING	SERVICES OMB NO. (300 R NUMBER: A BUILDING 5227 B. WING 12/1 5227 B. WING 577 5227 B. WING 12/1 5227 B. WING 12/1 5227 B. WING 577 5227 B. WING 12/1 5227 B. WING 577 522 F12/1 5802 CIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) 5 F 282 Compliance or the need for further audits. 6 a staff approach not reposition e. All departments will be updated of any resident on isolation precautions to include reason for isolation needed. 0 ns interviewed on minterventions and providing an 1 1/, directs care d with interventions and providing an 1 1/, directs care d with interventions and providing an 1 1/, directs care d with interventions and providing an 1 1/, directs care d vitho Nursing Home Administrator. 5 Date of Co

Facility ID: 00589

If continuation sheet Page 8 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA, IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245227	B. WING		· .	12/19/2013	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAVEUO				16	601 ST LOUIS AVENUE		
	RE RESIDENCE & RE			D	ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 8	F 2	82			
	nurse (RN-F) stated repositioned and to	13, at 12 noon with registered d that R23 was to be ileted every two hours.					
		led incontinence care and on 12/18/13, as the plan of needed.					
	indicated R23 was	dated as reviewed 11/13, to be assisted to the toilet th two staff and a mechanical					
	be laying on her ba assistant (NA-I) con changing R23's we not offered to use t had been placed on behind her back. R	on 12/18/13, at 4:30 a.m. to ack in bed. At this time nursing mpleted repositioning and t incontinent brief. R23 was he bedpan at that time. R23 n her left side with a pillow 23 was continually watched red her room, until 7:50 a.m. (3					
		13, at 12 noon with RN-F s to be toileted every two					
		2:20 p.m. interview with the (DON) indicated that staff e plan of care.					
	repositioning as the	vided every two hour e plan of care directed.			· ·		
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: GQM3	11	Fac	cility ID: 00589 If continu	uation shee	t Page 9 of 52

· .

-

		AND HUMAN SERVICES				FORM	: 01/14/2014 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´				E SURVEY IPLETED
	x	245227	B. WING			12	/19/2013
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 9	F	282			
	indicated R39 at ri dementia, immobili	dated as reviewed 11/6/13, sk for pressure ulcer due to ty, incontinence and needed aff to reposition at least every e as needed.					
	be laying on her rig NA-D completed re R39's incontinent b	on 12/18/13, at 4:25 a.m. to th side in bed. At that time positioning and changing prief. R39 had been placed on pillow behind her back.					
	and her wet inconti changed by NA-D. and remained on h	00 a.m. R39's was repositioned inent brief was checked and R39 was continually watched er left side facing the wall. No room, until 7:50 a.m. (3 hours					
	Interview with NA-I approximately 7:50 be repositioned eve	a.m. she stated R39 was to					
		wed on 12/18/13, at 12 noon 9 was to be repositioned and hours.					
	The facility failed to incontinence care care indicated was	every two hours as the plan of					
		(POC) dated as reviewed 39 was dependent with every					
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: GQM3	11	Fa	acility ID: 00589 If continu	ation shee	t Page 10 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´´		E CONSTRUCTION		E SURVEY PLETED	
		245227	B. WING			12/19/2013		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BAYSHO	RE RESIDENCE & RE	EHAB CTR			601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 282	Continued From pa	-	F2	282				
	R39 was observed be laying on her rig NA-D completed in continually observe a.m At 8:00 a.m. I care by NA-D (3 ho Interview with NA-E approximately 7:50 checked and chang Interview on 12/18/ nurse (RN-F) she s	on 12/18/13, at 4:25 a.m. to ht side in bed. At that time continence care. R39 was ed from 4:25 a.m. until 7:50 R39 was provided incontinence ours and 35 minutes).						
	timely manner accord R108's diagnoses dementia, renal ins disease, diabetes to the colon, and dep A car plan revised required reposition needed] in bed and On 12/18/13, R108 observation from 5 approximately 5:10 be dressed and sit pushed R108 into	11/19/13, directed R108 ing every 2 hours and prn [as						
		ed to push R108 in the broda ng room into R108's room.			acility ID: 00589			

Event ID: GQM311

Facility ID: 00589

.

If continuation sheet Page 11 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SUR COMPLETE	
		245227	B. WING			12/	19/2013
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR			601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	· (X5) COMPLETION DATE
F 282	NA-E covered R10 room light, and ask and exited R108's observed to be up the room. At 7:42 a R108's room with t from the broda cha approximately 30 s the chair. NA-E ren hoyer lift and tucke shoulders and hips door and exited the On 12/18/13, at 7:5 suppose to be reposince R108 was la a.m. R108 should than 7:30 a.m. On 12/19/13, at 10 care plan for every correct repositionin R108 was not repo according to the ca repositioning shou for a few seconds A certified occupat (COTA)-A failed to protective equipme hygiene as directed working with R34 Methicllin-resistan (MRSA) infection. R34's diagnoses i tracheostomy.	8 with a blanket, turned off the ed R108 wanted any tunes on, room. At 7:30 a.m. R108 was and asleep in broda chair in a.m. NA-E and NA-D entered he hoyer lift. NA-E was lifted ir with the lift sling for econds and lowered back into noved the lift sling from the d the ends around R108's b. NA-D opened R108's room e room with the hoyer lift. 53 a.m. NA-E stated R108 is ositioned every 2 hours and st repositioned around 5:00 have been repositioned sooner c00 a.m. RN-F stated R108's 2 hours repositioning was the ng schedule. RN-F confirmed ositioned in a timely manner, are plan. RN-F verified Id be more than lifting R108 up before lowering into the chair. tional therapy assistant wear appropriate personal ent (PPE) and perform hand id in the plan of care when		282			t Page 12 of 5

Event ID: GQM311

Facility ID: 00589

If continuation sheet Page 12 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245227	B. WING			12/	19/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	Continued From pa wear gowns, masks the residents room.	s and gloves prior to entering	F 2	82			
	outside R34's room isolation precaution contained PPE (go A certified occupati (COTA)-A was in F not wearing gloves in the bed. COTA w removed R34's cus placed it in a plastic to dispense hand s container in the res	05 a.m. a sign was noted indicating contact and droplet is. A cart outside the room wns, gloves and facial masks). onal therapy assistant R34's room wearing mask, but or a gown. R34 was observed vas next to the bed as she shion from a wheelchair and c bag. COTA-A then attempted anitizer from a wall mount sident's room; however, the ity. COTA-A did not wash her ing the room.				•	
	indicated R34 had she did not glove a providing direct can verified the hand sa	viewed at that time and MRSA in his nares and and gown because she was not re to the resident. COTA-A anitizer in the room was empty wash her hands prior to n.					
F 309 SS=D	DON) verified that gown and gloves w have washed her h 483.25 PROVIDE HIGHEST WELL E Each resident mus	8 p.m. the director of nursing (COTA-A should have worn a while in R34's room and should hands before leaving the room. CARE/SERVICES FOR BEING at receive and the facility must sary care and services to attain		309			
		hest practicable physical,					

Facility ID: 00589

7

If continuation sheet Page 13 of 52

.

		AND HUMAN SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245227	B. WING			12/	19/2013
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CO	DE	
BAYSHO	RE RESIDENCE & RI	EHAB CTR			1 ST LOUIS AVENUE LUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	accordance with th and plan of care. This REQUIREME by: Based on observa review, the facility health aid (HHA) h staff for 1 of 1 resid hospice services. Findings include: R13's diagnoses in history of a stroke anxiety, and depre Data Set (MDS) da had memory probl severe cognitive in to total assistance daily living (ADL's) bladder; was alwa received hospice s Recertification Sta 11/5/13, indicated services was vaso The facility care ph hospice involveme care, falls and hos did not indicate co	NT is not met as evidenced tion, interview and document failed to coordinate home ospice services with facility dents (R13) reviewed for ncluded vascular dementia, (CVA), seizure disorder, ession. The quarterly Minimum ated 10/16/13, indicated R13 ems (short and long term) with npairment; required extensive of staff with all activities of r; was frequently incontinent of ys incontinent of bowel; and services. The hospice itement for 60-day Period dated R13's diagnosis for hospice		309	F 309 1. Corrective Action: R 13 has expired 2. Corrective Action as to other residents: a. Any resident Hospice serv have care plane reviewed and to reflect corrective Action as to other residents: a. Any resident Hospice serve have care plane reviewed and to reflect corrective Action as to reflect corrective Action as to resident and the serve and the serve facility and H b. Hospice will the facility we schedule of HHA visits and to be provid 3. <u>Reoccurrence will be</u> <u>prevented by:</u> a. All nursing so inserviced of coordination between the and Hospice b. Any newly are residents to will have a comprehents plan coordin	t receiving vices will an d revised ordination veen the Hospice. provide with a planned nd services led. taff n of care e facility c. dmitted hospice sive care	

Facility ID: 00589

If continuation sheet Page 14 of 52

.

		AND HUMAN SERVICES	PRINTED: 01/14/201 FORM APPROVE OMB NO. 0938-039							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED			
		245227	B. WING			12/1	19/2013			
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
BAYSHO	RE RESIDENCE & RE	EHAB CTR			601 ST LOUIS AVENUE OULUTH, MN 55802					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 309	Continued From pa	ge 14	F3	809						
	The hospice care p 11/21/13, indicated services on 7/24/12 HHA to visit one to bath/bed bath/show care, nail care, peri needed, dressing, o positioning, transfe and assist with feed The HHA Visit Histo 11/14/13, to 11/21/1 tasks were complet 11/15/13 - Bath/sho care, peri care, toild dressing, changing transferring, sociali 11/18/13 - Bath/sho care, peri care, dre socializing, and tidy The record lacked identity of the HHA communication with was no documenta R13 was intermitte and afternoons of HHA visits were not On 12/18/13, at 1:1	lan dated as reviewed R13 was admitted to hospice 2. The care plan directed the two times a week to provide ver, mouth care, hair care, skin care, toileting/changing as change bed linens, foot soaks, rring, socialize, tidy room/bath, ding if present for meals. ory documentation dated from 13, indicated the following ted by the HHA: ower/bed bath, hair care, skin et/check and change, bed linens, positioning, zing, and tidy room/bath. ower/bed bath, hair care, skin ssing, positioning, transferring, / room/bath. the time of the HHA visits, the , and evidence of h facility staff. In addition, there tion of additional HHA visits. ntly observed on the mornings 12/18/13, and 12/19/13. No ited during the observations.			between facility ar Hospice. 4. <u>The Correction will be</u> <u>monitored by:</u> DON, Unit Managers, and designees with oversight b Nursing Home Administrat 5. <u>Date of Completion: 1/28/</u>	y or.				
	stated she was una	ely five other occasions. NA-B aware R13 received hospice ot know about any HHA visits.								

-

Facility ID: 00589

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245227	B. WING			12/1	19/2013		
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE				
BAYSHO	RE RESIDENCE & RE	EHAB CTR		DULUTH, MN 55802					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX ;	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 309	Continued From page 15		F	309					
	manager (RN)-F st frequency, days, or registered nurse (F	0 p.m. the registered nurse ated she was unaware of the times of the hospice RN) or HHA visits for R13. dn't believe there was any type			·				
	aide (TMA)-A state day/time the hospic	09 p.m. the trained medication d she was unsure exactly what ce aide visited, but thought it TMA-A stated she thought the alked with R13.							
	they had routinely NA-O stated she h she came on Mono the HHA visited. Bo the HHA sat with R hands, but were un actually provided for	25 p.m. NA-O and NA-D stated cared for R13. ad seen the HHA and thought days. NA-D was unsure when oth NA's stated they thought t13, talked, and lotioned her nsure what cares the HHA or R13. NA-O added, the HHA some cares, "But they don't do							
	(DON) was questic care between the The DON verified to know when the what they do when 12/19/13, at 4:49 p medical record lac hospice aide visits The DON stated s	22 a.m. the director of nursing oned regarding coordination of facility and hospice agency. there should be a way for staff hospice aides are coming, and in they're in the facility. On o.m. the DON confirmed R13's ked evidence of when the or what cares were completed. he called the hospice nurse that the HHA documentation			;				

Facility ID: 00589

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			12/1	19/2013
NAME OF I	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 F 312 SS=D	medical record. The coordination betwee 483.25(a)(3) ADL C DEPENDENT RES A resident who is u daily living receives maintain good nutri and oral hygiene. This REQUIREMEN by: Based on observat review, the facility f provided for 1 of 3 activities of daily liv Findings include: R33 had long finge under the nails. R33's diagnoses in glaucoma. The adr (MDS) dated 9/4/13 extensive assistand hygiene (including 9/11/13 indicated R activities of daily liv	cility to be placed into R13's e DON verified the lack of en the facility and the hospice. CARE PROVIDED FOR IDENTS nable to carry out activities of the necessary services to tion, grooming, and personal NT is not met as evidenced tion, interview and document ailed to ensure nail care was residents (R33) reviewed for		309	 F 312 1. <u>Corrective Action:</u> a. R 33 nails have been cleaned and trimmer by licensed staff 2. <u>Corrective Action as it applition other residents:</u> a. Reviewed and revise nail care policy to include diabetic nail care. b. 100% audit of all residents to ensure nail care is complete per plan of care. 3. <u>Reoccurrence will be prevented by:</u> a. All nursing staff inserviced on the revised nail care point to be checked that th are clean and trimmer weekly x 1 month to monthly x2. Result will be reported to Quality Assurance Committee to asset 	ed ies sed il ted blicy. to ey med then ts the	
					for ongoing		

⁻ORM CMS-2567(02-99) Previous Versions Obsolete

T

Facility ID: 00589

If continuation sheet Page 17 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	01/14/2014 PPROVED 938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			12/19/2013	
	ROVIDER OR SUPPLIER	EHAB CTR		. 160	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	age 17	F	312			
	long, untrimmed fir the nails. R33 was 1:27 p.m. and state	7 p.m. R33 was observed with gernails that had debris under interviewed on 12/19/13, at ed the nurses provide nail care.			compliance or the need for further audits. 4. <u>The Correction will be</u> <u>monitored by:</u>		·
	(RN)-C was intervi nurses are to com residents. On 12/1	39 p.m., registered nurse ewed and stated licensed olete nail care for diabetic 9/13, at 2:28 p.m. the director rerified diabetic nail care is to y licensed staff.			DON, Unit Managers, and designees with oversight I Nursing Home Administra 5. <u>Date of Completion: 1/28</u>	oy tor.	
F 314 SS=E	procedure on diab 483.25(c) TREAT		F	314			
	resident, the facilit who enters the fac does not develop individual's clinica they were unavoid pressure sores re- services to promo	n the comprehensive assessment of a , the facility must ensure that a resident ers the facility without pressure sores t develop pressure sores unless the al's clinical condition demonstrates that re unavoidable; and a resident having e sores receives necessary treatment and to promote healing, prevent infection and new sores from developing.					
	by: Based on observ review, the facility to prevent the dev	ENT is not met as evidenced ation, interview and document failed to provide repositioning velopment of pressure ulcers or of pressure ulcers for 4 of 4 R23, R39, R108).					

ı

Facility ID: 00589

If continuation sheet Page 18 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	01/14/2014 PPROVED		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		245227	B. WING			12/19/2013			
NAME OF F	PROVIDER OR SUPPLIER								
BAYSHO	RE RESIDENCE & RE	EHAB CTR							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 314	Continued From pa	ge 18	F3	314					
	Findings include:				<u>F 314</u>				
	R125 was not repo plan.	sitioned as directed in the care			 <u>Corrective Action:</u> R 125 has expired R 23, R 39, and R care plans and group 	108			
	Pressure Ulcer Sta Pressure Ulcer Adv	ges (defined by the National isory Panel)			sheets reviewed a revised as needed	ind			
	localized area usua The area may be p	hable erythema -blanchable redness of a ally over a bony prominence. ainful, firm, soft, warmer or d to adjacent tissue.			appropriate repositioning to prevent pressure sores. 2. <u>Corrective Action as it app</u>	olies			
	shallow open ulcer without slough. Ma open/ruptured seru	ss of dermis presenting as a with a red pink wound bed, y also present as an intact or m-filled or sero-sanginous nts as a shiny or dry shallow			<u>to other residents:</u> a. 100% audit of all resident care plan group sheets who pressure sores or are at risk based o	have who			
	be visible but bone exposed. Slough m obscure the depth undermining and tu visible or directly p	e loss. Subcutaneous fat may , tendon or muscle are not hay be present but does not of tissue loss. May include inneling. Bone/tendon is not alpable.			the comprehensiv assessment to ens that an appropria repositioning plan care is in place. 3. <u>Reoccurrence will be</u> <u>prevented by:</u>	sure te			
FORM CMS 2	tendon or muscle. present. Often inclu	e loss with exposed bone, Slough or eschar may be udes undermining and I bone/muscle is visible or	11	Fac	a. All nursing staff in serviced on press sore	ıre	Page 19 of 52		

•

	MENT OF HEALTH	AND HUMAN SERVICES			. 0	MB NO. (PPROVED)938-0391
ENTER!	S FOR MEDICARE	& MIEDICAID CERVICE	(X2) MU	TIPLEC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
PLAN DF	OF DEFICIENCIES	IDENTIFICATION NUMBER:	A BUILD	NG			
		245227	B. WING	;		12/1	9/2013
		240221		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			1601	1 ST LOUIS AVENUE LUTH, MN 55802		
AYSHO	RE RESIDENCE & R			1	THE REPORT OF AN OF CORRECTION		(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIEND REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAI	FIX	(EACH CORRECTIVE ACTION SHOUL (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
			F	314			
F 314	Continued From p	age 19			prevention/treat	ment	
) (nstaneahle/()0C	lassified: Full thickness skin or	r 🖌	ļ	with repositionin		
				. [b. Daily audits x 1 v		}
		sue loss in which actual depth letely obscured by slough		ł	and then 2 x we		
-			ar	ł	2 months to assi	ure	
	(tan, brown or bla	ack) in the wound been and	\ .		repositioning	-210	
	I expose the base	OF THE WOLLIN, THE AND POPUL	1		completed per o plan. Results w		
	cannot be determ	nneo.			reported to the		
	R125's diagnose	es included dementia, chronic	. {		Assurance Com		
		on, generalized weakness, and trition. The significant change	■ . 		to assess for on		
	List Law Doto S		ł		compliance or t		
	indicated R125	had modelately inipation had			need for furthe	r .	
	DIST. MARKED (DIT		zed		audits.		
					 <u>The Correction will be</u> monitored by: 		
	16	ive assistance with bed mobili currently had a Stage I pressur	· · · · ·		DON, Unit Managers, a	ind	l
					Designees with oversig		
	and repositionil	ng schedule, and was at risk for nt of pressure ulcers.	-		Nursing Home Adminis	strator	Į
•		····			5. Date of Completion: 1	/28/14	
	The Care Area	Assessment (CAA) dated 12/	2/13,		Addendum to # 3.		
						hearin	ation
:	pressure ulcer	s due to incontinence of assist	twith		C. Direct Care C	1.201 40	
					to be completeted	wee	
		left elbow. The CAA also indica urrent Stage I pressure ulcer			E results reported	to the	· Celebrity
	i i - Haa aati				assurance committe	ee to	ausess
\		eat cushion to reduce or relievent required a regular schedule c	of		c. Direct care a to be completeted E results reported assurance committe for ongoing complue	uce 14	28/14 55
1	pressure, and turning.	I Edulled a logan. come and			for ungun) on p	-1	

.

``.

_

-Jan. 28. 2014 6

AND PLAN OF CORRECTION	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (X3) COMPLETED
245227 B.	
	B. WING 12/19/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
 F 314 Continued From page 20 R125's care plan updated 11/27/13, indicated a stage III pressure ulcer to the left hip and directed staff to redistribute pressure with repositioning, check feet and heel and other bony prominence during repositioning, and to reposition R125 every one and one half hours due to non-compliance with position changes. The care plan further directed to check for skin changes every shift and as needed, and to update the team leader of any changes. The nursing assistant care guide lacked a repositioning schedule. On 11/27/13, the progress notes indicated R125 had a Stage III pressure ulcer on the left hip, the wound care nurse would follow monthly, and the registered nurse (RN) would monitor, measure and document weekly. Progress notes from 11/27/13, through 12/16/13, did not address the pressure ulcer on the R125's left hip. 	F 314
 R125's skin ulcer data collection and assessment indicated the following: 11/27/13: Stage III pressure ulcer to left hip, measuring 0.9 centimeters (cm) x 0.6 cm. 12/3/13: Unstageable pressure ulcer to left hip, measuring 1 cm x 0.7 cm. 12/13/13: Unstageable pressure ulcer to left hip, measuring 1 cm x 1 cm. RN-C was interviewed on 12/17/13, at 10:30 a.m and stated R125 had an unstageable pressure ulcer of the left hip. R125 was continuously observed in the 	
R125 was continuously observed in the FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GQM311	1 Facility ID: 00589 If continuation sheet Page 2

,

		AND HUMAN SERVICES					01/14/2014 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
		245227	B. WING	;		12/1	9/2013		
NAME OF F	PROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE				
BAYSHO	RE RESIDENCE & RE	EHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 314	wheelchair on 12/1 10:05 a.m R125 w propelled his whee dining room where the unit. At no time staff approach R12 R125 did not repos surveyor informed repositioning. At 1 (NA)-A transferred was observed with stated R125 had ha on the left hip that further stated the le open, "But it is now pressure area at 0 it was a Stage II. R ulcer, applied a de covered it with gau On 12/19/13, at 2:3 and stated R125 w but usually refuses On 12/18/13, at 2:3 and verified the nu sheet lacked repos further stated she repositioning R125 On 12/19/13, at 11 ulcers are docume should have been pressure ulcer to t The director of nut 12/19/13 at approx	 8/13, from 7:25 a.m. through vas dressed for the day, and lchair from his room, into the he ate breakfast, and back to during the observation did 5 to offer repositioning and ition himself. At 9:45 a.m. the RN-D regarding R125's lack of 0:05 a.m. nursing assistant R125 into bed. R125's skin RN-C at 10:08 a.m. RN-C ad a recurring pressure ulcer opens and closes. RN-C eff hip ulcer had not been //" RN-C measured the 8 cm x 0.8 cm and later stated N-C cleansed the pressure rmagauze dressing and ize. 59 a.m. NA-B was interviewed, vas approached to reposition, s. 22 p.m. RN-C was interviewed rsing assistant assignment sitioning directions. RN-C would expect staff to be 5 every one and a half hours. :49 a.m. RN-C stated pressure ented in the skin book, and it documented when the he left hip healed. rsing (DON) was interviewed on kimately 3:00 p.m. The DON 		314		inuation sheet	Page 22 of 52		
FORM CMS-2	2567(02-99) Previous Versior	ns Obsolete Event ID: GQM:	311	F	Facility ID: 00589 If cont	inuation sheet	Page 22 of 52		

		AND HUMAN SERVICES			· · · · ·	FORM	01/14/2014 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION G		E SURVEY PLETED			
		245227	B. WING	;		12/	19/2013			
NAME OF F	PROVIDER OR SUPPLIER	L	L		STREET ADDRESS, CITY, STATE, ZIP CODE					
BAYSHO	RE RESIDENCE & RE	EHAB CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 314		nge 22 xpect staff to follow the care ositioning schedule.	F	314	4					
	assessment and ca plan interventions a consideration of res	sident choice, interventions redistribution, and providing an								
	R23 was not provid repositioning assis indicated was need	stance as the assessment								
	had severe cognitive non-ambulatory, re- from two staff to tra- limitations in the up was always incontion MDS also indicated ulcer, had a history	dated 11/20/13, indicated R23 ve impairment, was equired extensive assistance ansfer, had range of motion oper and lower extremities and nent of urine. The quarterly d R23 was at risk for pressure v of buttocks pressure ulcers e that increased the risk of								
	R23 was at risk for diagnosis of demen antidepressant use positioning devices frequency of bladd assessment indica had potential of frid in a chair. R23 wa	ent dated 8/21/13, indicated alteration in skin due to ntia, Parkinson, neuropathy, e, antipsychotic use, use of a s (body pillow) and the er incontinence. The ted R23 was chair bound and ction shearing due to slouching as assessed to require every epositioning with extensive staff.								

Facility ID: 00589

If continuation sheet Page[,] 23 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245227	B. WING	i		12/1	19/2013
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 23	F	314			
	dated 12/3/13, indi pressure ulcer on t	a Collection and Assessment cated R23 had a stage one he buttocks measuring 8 cm artial thickness of skin.			~		
	11/13, indicated R assistance for repo in bed. The undate	POC) dated as being reviewed 23 required extensive ositioning every two hours when ed Nursing Assignment I every two hour repositioning.					
	back in bed and N/ and repositioning. red areas above th was approximately with peeling skin. T the buttocks creas long by 1/8 inch wi left side with a pillo remained in that pe a.m., R23 was pro- left hip and lateral an area four inche and NA-J used a r assist R23 onto the hip redness resolv	30 a.m., R23 was laying on her A-I provided incontinence care R23 was observed to have two be coccyx area. The first area two inches by three inches The second area was located in e, approximately two inches de. R23 was positioned on the bw behind the back and osition until 7:50 a.m At 8:08 ovided incontinence care. The leg were observed to be red in s by seven inches long. NA-L nechanical standing lift to e toilet. After 20 minutes the ed; however, the buttocks area had been when observed at					
	8:30 a.m., stated F every two hours. V	on 12/18/13, at approximately R23 was to be repositioned When asked what time R23 was before getting up at 8:08 a.m.,					t Page 24 of 52

Facility ID: 00589

If continuation sheet Page 24 of 52

.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245227					12/	19/2013
NAME OF	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHC	BAYSHORE RESIDENCE & REHAB CTR				1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	•	but the night shift would have	F	314	4		
	stated that R23 wa every two hours. V assistants were su were last toileted a the information was	n 12/18/13, at 12 noon, RN-F s to be positioned and toileted When asked how were nursing ppose to know when residents nd repositioned, RN-F stated s on the care sheets; however, ould not be located.					
		ded repositioning every two ssment indicated was needed.					
	had moderate cogn incontinent of bowe extensive assistan bed mobility, trans	dated 10/23/13, indicated R39 nitive impairment, was always el and bladder, required ce or two or more staff with fers and toileting, was at risk s, and had a repositioning			· · · · · · · · · · · · · · · · · · ·		
	R39's was at risk f	nent dated 7/31/13, indicated or alteration in skin due to obility, preference to remain in d the potential for friction skin			· · · ·		
	indicated R39 req	ated as reviewed 11/13, uired assistance for turning and ast every 2 hours and more r as requested. It noted R39			Facility ID: 00589 If continu		t Page 25 of 5

-

STATUBLEN OF EXPERIENCES (X1) PARCE ONSTRUCTION (X2) PARCE NUMPY (X2) PARCE NUMPY AND PLAN OF CORRECTION 245227 Is WING 12/19/2013 ANALE OF FROMDER OR SUPPLIER 245227 Is WING 12/19/2013 DAVE OF FROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12/19/2013 DAVE OF FROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ST LOUIS AVENUE DAVE OF FROMMERY STATEMENT OF DEPICIENCIES Interview of the CORRECTIVE ACTION SHOULD BE 000000000000000000000000000000000000			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE, ZIP CODE BAYSHORE RESIDENCE & REHAB CTR Ist out of the state of the red areas was approximately one and one half inches round. IM ID: HOULTH, MN SUMMARY STATEMENT OF DEFICIENCIES (EAC) EXERCISION WAST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ib PROVIDERS FLAV OF CORRECTION (EAC) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWNED CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 314 Continued From page 25 needed pressure relieving/reducing device on bed and chair. The undated Nursing Assignment worksheet directed every two hour repositioning. F 314 R39 was observed on 12/18/13, at 4:25 am. to be laying on her right side in beack. RS9 remained on the left side during continuous observation until 7:50 a.m. (3 hours and 35 minutes) with out repositioning. At 300 a.m., NA-1 was observed to provide incontinence care and repositioning. At that time the left duet malleous (ankle) was slightly red and another area anterior to the left malleous was also red. Each of the red areas was approximately one and one half inches round. NA-D was interviewed on 12/18/13, at approximately 7:50 a.m. and stated R39 was to be repositioned every two hour incontinence care and repositioning. R108 was not repositioned as directed by the plan of care.	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1			(X3) DAT CON	E SURVEY IPLETED
BAXSHORE RESIDENCE & REHAB CTR 1601 ST LOUIS AVENUE DULUTH, MN 55802 CM10 PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION BROUDD BE REQUARDRY OR LIS DENTFLYING INFORMATION) ID PRETX TAS PROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION BROUDD BE REQUARDRY OR LIS DENTFLYING INFORMATION) ID PRETX TAS PROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION BROUDD BE REQUARDRY OR LIS DENTFLYING INFORMATION) ID PRETX (EACH CORRECTIVE ACTION BROUDD BE REQUARDRY OR LIS DENTFLYING INFORMATION) ID PRETX (EACH CORRECTIVE ACTION BROUDD BE REQUARDRY OR LIS DENTFLYING INFORMATION) ID PRETX (EACH CORRECTIVE ACTION BROUDD BE REQUARDRY OR LIS DENTFLYING INFORMATION) ID PRETX (EACH CORRECTIVE ACTION BROUDD BE REQUARDRY OR LIS DEBUTION BROUDD BE REQUARDRY OR LIS DEBUTION (EACH CORRECTIVE ACTION BROUDD BE REQUARDRY OR LIS DEBUTION (EACH CORRECTION BROUDD BE REQUARDRY OR LIS DEBUTION (EACH CORRECTION (EACH CORRECTION BROUDD BE REQUERTED BE REQUERTED BE REQUARDRY OR LIS DEBUTION (EACH CORRECTION BROUDD BE RECURDED BE REQUERTED BE RECURDED BE RECURD			245227	B. WING			12/	19/2013
EAXSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802 Image: Control of the control of th	NAME OF F	PROVIDER OR SUPPLIER						
Model reach Deprocessor Austree Proceeding of Youl, RESULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAS reach consecution of the ACTION SHOULD BE CROSS-REFERENCE OT IN HEAD PROPERTIAN DEFICENCY) COMMENTION INFORMATION F 314 Continued From page 25 needed pressure relieving/reducing device on bed and chair. The undated Nursing Assignment worksheet directed every two hour repositioning. F 314 F 314 R39 was observed on 12/18/13, at 4:25 a.m. to be laying on her right side in bed. NA-1 provided incontinence care and repositioning. At that time the left side during continuous observation until 7:50 a.m. (3 hours and 35 minutes) with out repositioning. At 4:800 a.m., NA-1 was observed to provide incontinence care and repositioning. At that time the left outer malleous (ankle) was slightly red and another area anterior to the left malleous was also red. Each of the red areas was approximately one and one half inches round. NA-D was interviewed on 12/18/13, at approximately 7:50 a.m. and stated R39 was to be repositioned every two hour. Incontinence care and repositioning. RN-F was interviewed on 12/18/13, at 12 noon and stated F39 required every two hour incontinence care and repositioning. R108 was not repositioned as directed by the plan of care.	BAYSHO	RE RESIDENCE & RE	EHAB CTR					
needed pressure relieving/reducing device 0n bed and chair. The undated Nursing Assignment worksheet directed every two hour repositioning. R39 was observed on 12/18/13, at 4:25 a.m. to be laying on her right side in bed. NA-1 provided incontinence care and repositioning to the left side with a pillow to the back. R39 remained on the left side during continuous observation until 7:50 a.m. (3 hours and 35 minutes) with out repositioning. At 8:00 a.m., NA-1 was observed to provide incontinence care and repositioning. At that time the left outer malleolus (ankle) was slightly red and another area anterior to the left malleolus was also red. Each of the red areas was approximately one and one half inches round. NA-D was interviewed on 12/18/13, at approximately 7:50 a.m. and stated R39 was to be repositioned every two hours. When asked what time R39 was last repositioned, NA-D did not know. RN-F was interviewed on 12/18/13, at 12 noon and stated F39 required every two hour incontinence care and repositioning. R108 was not repositioned as directed by the plan of care.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
be laying on her right side in bed. NA-I provided incontinence care and repositioning to the left side with a pillow to the back. R39 remained on the left side during continuous observation until 7:50 a.m. (3 hours and 35 minutes) with out repositioning. At 8:00 a.m., NA-I was observed to provide incontinence care and repositioning. At that time the left outer malleolus (ankle) was slightly red and another area anterior to the left malleolus was also red. Each of the red areas was approximately one and one half inches round. NA-D was interviewed on 12/18/13, at approximately 7:50 a.m. and stated R39 was to be repositioned every two hours. When asked what time R39 was last repositioned, NA-D did not know. RN-F was interviewed on 12/18/13, at 12 noon and stated F39 required every two hour incontinence care and repositioning. R108 was not repositioned as directed by the plan of care.	F 314	needed pressure re bed and chair. The	elieving/reducing device on undated Nursing Assignment	F	314			
approximately 7:50 a.m. and stated R39 was to be repositioned every two hours. When asked what time R39 was last repositioned, NA-D did not know. RN-F was interviewed on 12/18/13, at 12 noon and stated F39 required every two hour incontinence care and repositioning. R108 was not repositioned as directed by the plan of care. R108 was not repositioned as directed by the plan of care.		be laying on her rig incontinence care a side with a pillow to the left side during 7:50 a.m. (3 hours repositioning. At 8 provide incontinent that time the left ou slightly red and and malleolus was also was approximately	ht side in bed. NA-I provided and repositioning to the left to the back. R39 remained on continuous observation until and 35 minutes) with out 00 a.m., NA-I was observed to be care and repositioning. At atter malleolus (ankle) was other area anterior to the left red. Each of the red areas					
and stated F39 required every two hour incontinence care and repositioning. R108 was not repositioned as directed by the plan of care.		approximately 7:50 be repositioned ev what time R39 was	a.m. and stated R39 was to ery two hours. When asked					
plan of care.		and stated F39 rec	uired every two hour					
R108's diagnoses included dementia, renal			ositioned as directed by the					
		R108's diagnoses	included dementia, renal					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	01/14/2014 APPROVED 0938-0391
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245227					12/1	9/2013
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	insufficiency, coron type 2 and malignat The annual MDS da had short and long-	ary artery disease, diabetes nt neoplasm of the colon. ated 11/21/13, indicated R108 term memory problems, had	F	314			
· ·	decision making, au disorganized thinkin indicated R108 had behaviors with verb directed towards ot provision of cares. required extensive and was totally dep	cognitive skills for daily nd displayed inattention and ng behaviors. The MDS further l occasional delusional oal and physical behavior hers and occasionally rejected The MDS also indicated R108 assistance with bed mobility bendent with transfers, toileting, and bathing activities.					
	R108 had a healed no skin breakdown The assessment fu repositioned, check and a half hours, h	t dated 11/13/13, indicated pressure ulcer on a heel with at the time of assessment. In ther indicated R108 was to be ked and changed every one ad a cushion in the broda igh risk for skin breakdown.					
		i 11/19/13, directed R108 ing every 2 hours and prn [as I broda chair.					
	observation from 5 5:04 a.m. R108 wa have the legs and t of the bed. NA-I ar with a hoyer lift and	was under continuous :04 a.m. until 7:42 a.m. At s yelling out was observed to feet hanging out over the edge nd NA-J entered R108's room d closed the door. At 0 a.m. R108 was observed to					

Facility ID: 00589

If continuation sheet Page 27 of 52

de la servición de la defensión

		AND HUMAN SERVICES				FORM A	01/14/2014 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		E CONSTRUCTION	(X3) DATE	
		245227	B. WING		·	12/19/2013	
NAME OF F	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
-				16	601 ST LOUIS AVENUE		
BAYSHO	RE RESIDENCE & RE			D	ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	pushed R108 into t unit. R108 remaine a.m. NA-E pushed the dining room into R108 with a blanke and asked R108 wi exited the room. A asleep in broda cha NA-E and NA-D en hoyer lift, secured f unbuckled R108's the seat of the broo seconds. NA-E brief incontinent brief for lowered back into t the lift sling from the ends around R108 a.m. NA-E remove hands, asking if R ² NA-E prepared a w wiped R108's face with a hand towel. then re-buckled R ² chair. NA-E sanitiz R108 in the broda On 12/18/13, at 7:3 suppose to be repo since R108 was la a.m. R108 should than 7:30 a.m. On 12/19/13, at 100 care plan for every correct repositionin R108 was not repo	ing up in the broda chair. NA-I he dining room area on the d in the dining room until 5:55 I R108 in the broda chair from o R108's room. NA-E covered et, turned off the room light, anted any tunes on, and then t 7:30 a.m. R108 remained air in the room. At 7:42 a.m. thered R108's room with the the lift sling to the hoyer lift, seat belt, and raised R108 off da chair for approximately 30 efly examined R108's r wetness before R108 was the chair. NA-E disconnected he hoyer lift and tucked the 's shoulders and hips. At 7:45 d the gloves and sanitized her 108 would like a face wash. varm, wet wash cloth and and then dried R108's face NA-E brushed R108's hair and 108's seat buckle in the broda zed her hands and pushed chair out into the hallway. 53 a.m. NA-E stated R108 was ositioned every 2 hours and ist repositioned around 5:00 have been repositioned sooner		314			Page 28 of 52
FORM CMS-2	2567(02-99) Previous Versior	ns Obsolete Event ID: GQM3	311	Fa	acility ID: 00589 If continua	tion sheet	Page 28 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245227	B. WING	÷		12/19/2013		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE			
BAYSHO	RE RESIDENCE & RE	EHAB CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314 F 315 SS=D	according to the car should be more that seconds before low A Skin Assessment revised 5/2011, direct receive the necessar prevent the develop other skin problems individualized repose 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the fact resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servit infections and to reat function as possible This REQUIREMEN by: Based on observat review, the facility fa assistance with inco	re plan; and that repositioning n lifting R108 up for a few eering into the chair. and Care policy reviewed and ected each resident would ary care and services to oment of pressure ulcers or and would include an sitioning schedule. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder e. NT is not met as evidenced ion, interview, and record ailed to provide timely ontinence cares directed by 2 of 4 residents (R23, R39).		314	 F 315 1. Corrective Action: R23 and R39 care plans an group sheets reviewed and revised as needed for appropriate incontinence of 2. Corrective Action as it app to other residents: 100% audit of all resident plans and group sheets wh require incontinence care ensure that appropriate interventions are in place. 3. <u>Reoccurrence will be</u> <u>prevented by:</u> a. All nursing staff w in serviced on incontinence care b. Daily audits x 1 we and then 2 x weel 2 months to assur repositioning and incontinence care completed per ca plan. Results will reported to the O Assurance Comm to assess for ongo 	d care. lies care nom to ill be ill be eek dy x e /or re be uality ittee ping		
ORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: GQM31	1	F:	acility ID: 00589		Page 29 of 52	

If continuation sheet Page 29 of 52

ENTER!	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULI A. BUILDI	TIPLE CO	NSTRUCTION	COM	e survey Pleted
PLANOF	CORLEGION	245227	B. WING		710		19/2013
	ROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP ST LOUIS AVENUE		
	RE RESIDENCE & F			DUL	UTH. MN 55802		(X5)
AYSHU (X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF C (EACH CORRECTIVE ADTIC CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	DATE ·
F 315	incontinence can indicated was need The incontinence dated 8/21/13, in incontinence an activities of daily contributing fact included delirium restricted mobil The quarterly M 11/20/13, indication impaired, requist staff for transfer motion to upper always inconting The quarterly assessment of functional bla assessment transfers on/of disc or mech bedpan, inco- and changing that R23 neight every two ho staff. R23's plan of indicated R	to provide K25 with e 12/18/13, as the assessment reded. e Care Area Assessment (CAA) dicated R23 had bladder d required staff assistance for y living. The assessment noted fors to R23's incontinence m, psychological problems, pai ity and urinary urgency. Alinimum Data Set (MDS) dated ated R23 was severely cognitiv- ired extensive assistance or two ars, had limitations in range of er and lower extremities and wa nent of urine bowel and bladder status lated 11/20/13, indicated R23 dder and bowel incontinence. T indicated staff were to provide a anical lift, assist with the use of portinence care, adjusting clothing of incontinence brief. It conci- eded to be toileted and repositiv- ours with extensive assistance of the machanical status and repositiv- tions with extensive assistance of the set	had he all he all he all the mg, uded oned of two 3, with 23 was	315	need for audits. 4. <u>The Correction w</u> <u>monitored by:</u> DON, Unit Mana Designees with Nursing Home A 5. <u>Date of Comple</u> Addendum to t C. Direct to be complete results reported assurance e com for ongoing com	vill be agers, and oversight by Administrator <u>tion: 1/28/14</u> # 3 Care obsi 22 weekly 2 to the unittee to pliance - 1	75 78/14
	to be toilete	ed every two hours and es the		1	Facility ID: 00589	lf continuati	on sheet Page 30 p
FOR	M CM5-2567(02-99) Previo	us Versions Obsolete Even					•
1							

		AND HUMAN SERVICES				FORM	: 01/14/2014 IAPPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245227	B. WING			12	/19/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR			D1 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	The facility failed to	provide R23 with 12/18/13, as the assessment	F 3	315	need for further		
	dated 8/21/13, indi- incontinence and re activities of daily liv contributing factors included delirium,	Care Area Assessment (CAA) cated R23 had bladder equired staff assistance for all ving. The assessment noted to R23's incontinence psychological problems, pain, and urinary urgency.			audits. 4. <u>The Correction will be</u> <u>monitored by:</u> DON, Unit Managers, and Designees with oversight Nursing Home Administra 5. <u>Date of Completion: 1/28</u>	by tor	
	11/20/13, indicated impaired, required staff for transfers,	num Data Set (MDS) dated R23 was severely cognitively extensive assistance or two had limitations in range of Id lower extremities and was of urine			·		
	assessment dated functional bladder assessment indica transfers on/off toi disc or mechanica bedpan, incontine and changing of in that R23 needed	el and bladder status 11/20/13, indicated R23 had and bowel incontinence. The ated staff were to provide all let with assist of two and a pivor I lift, assist with the use of the nce care, adjusting clothing, continence brief. It concluded to be toileted and repositioned ith extensive assistance of two	t		· · · · · · · · · · · · · · · · · · ·		
	indicated R23 wa two staff and a me	dated as reviewed 11/13, s to be assisted to toilet with echanical sit/stand lift. R23 was y two hours and as needed					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245227	B. WING			12/1	9/2013
NAME OF F	ROVIDER OR SUPPLIER	1			REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			01 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 30	F	315			
		s. Resident was to be assisted bed pan when in bed. Staff ntinence care.			• •		
	•						
	be laying on her ba assistant (NA-I) cor	on 12/18/13, at 4:30 a.m. to ick in bed. At that time nursing mpleted repositioning and	•				
	placed on her left s back, she was not	ontinent brief. R23 had been ide with a pillow behind her offered the bed pan at that tinually observed and no staff					
	entered her room fi On 12/18/13, at 8:0 brief was checked	rom 4:30 a.m. until 7:50 a.m 08 a.m. R23's wet incontinent and changed by NA-L. R23 e toilet by NA-L and NA-J with					
	8:30 a.m., NA-L sta repositioned, check hours. NA-L did no	n 12/18/13, at approximately ated R23 was to be ked and changed every two ot know when R23 was anged before getting up at 8:08					
	a.m	· · · · ·					
	12/18/13, at 12 not repositioned and t	RN)-F, interviewed on on, stated that R23 was to be oileted every two hours. When assistants were suppose to					
	know when resider repositioned when said that they could looked where the c were suppose to b	a new work shift came on, she d look at the care sheets. RN-F completed resident care sheets e kept, but there was no care					
	sheet for R23.						

1 1.1.1.1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GQM311

Facility ID: 00589

If continuation sheet Page 31 of 52

		AND HUMAN SERVICES				FORM A	01/14/2014 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245227	B. WING			12/1	9/2013
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	Continued From pa	age 31	F	315			
	R39 was not provic two hours as the as needed.	ded incontinence care every ssessment indicated was					
	7/31/13, indicated I and bladder and de toileting needs. R3 for dignity, was ask needed to use the were to provide pe	adder Assessment dated R39 was incontinent of bowel ependent on staff for all of her 9 wore an incontinence brief ked every two hours if they toilet but usually refuses. Staff prineal care, brief changes, at prior to and after toileting.					
	bladder incontinen assistance with all assessment identif including delirium,	21/13 indicated R39 had ce and required staff activities of daily living. The fied risk factors of incontinence psychological problems, pain, and urinary urgency.					
	moderate cognitive	6 dated 10/23/13, identified e impairment, dependence mobility, transfers, and					
	indicated R39 was toileting and requir care every two hou undated Nursing A	e dated as reviewed 11/13, s dependent upon staff for red check/change incontinence urs and as needed. The Assignment worksheet directed o check/change and toilet every needed.					
FORM CMS-2	R39 was observed	d on 12/18/13, at 4:25 a.m. to	M311	F	acility ID: 00589 If continu	ation sheet	Page 32 of 52

		AND HUMAN SERVICES				FORMA	01/14/2014 PPROVED)938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		245227	B. WING			12/1	9/2013
	ROVIDER OR SUPPLIER	EHAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315 F 323 SS=D	provided incontiner R39 was continual until 7:50 a.m At 8 incontinence care. During interview or 7:50 a.m., NA-D s and changed every when R39 was pre care. RN-F, interviewed stated that R39 was toileted every two I nursing assistants residents had beer when a new work s they could look at R39's care sheet v 483.25(h) FREE O HAZARDS/SUPER The facility must e environment rema as is possible; and adequate supervis prevent accidents. This REQUIREME by:	ht side in bed and NA-D nee care and repositioning. y observed from 4:25 a.m. 3:00 a.m., NA-D provided h 12/18/13, at approximately tated R39 was to be checked y two hours. NA-D did not know viously provided incontinence on 12/18/13, at 12 noon, is to be repositioned and nours. When asked how were suppose to know when the n last toileted and repositioned shift came on, RN-F stated that the care sheets; however, vas not located. F ACCIDENT RVISION/DEVICES insure that the resident ins as free of accident hazards l each resident receives ion and assistance devices to ENT is not met as evidenced ation, interview and document		315	 <u>F 323</u> <u>Corrective Action:</u> R 120's fall of 12/12/13 was been reviewed on 12/20/1 IDT care plan and group sh audited to assure that fall prevention strategies implemented. <u>Corrective Action as it app</u> to other residents: 100% audit of all care plan and group sheets to assure assessed fall prevention interventions are correctly place. <u>Reoccurrence will be</u> <u>prevented by:</u> a. All licensed nursin staff will be in ser on Fall Prevention Policy Daily morning me will include Risk Management-IDT Incident/Accident review of all falls prior 24 hours. A will be completed assessment/care 	3 by heet lies hs e all y in y in hg viced h heting t the hudit d on	
FORM CMS-2	567(02-99) Previous Versior	ns Obsolete Event ID: GQM3	 311	Fa	acility ID: 00589 If continuation	tion sheet	Page 33 of 52

ENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO	E SURVEY
EMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CON	IPLETED
		245227	B. WING _			19/2013
ME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	νE	
	RE RESIDENCE & RI	EHAB CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		
X4) ID REF1X	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
TAG	REGULATORI OR					
F 323	Continued From pa	age 33	F 3	23	. · ·	
	comprehensive as of 3 residents (R1)	sessment following a fall for 1 20) reviewed for accidents.		update and it action requir		
				4. The Correction will b		
	Findings include:			monitored by:		
				DON, Unit Manager,		
	R120 was admitte	ed from a hospital due to		Designees with over	sight by	
	Lincreasing falls DE	er the hospital discharge /27/13. R120 had an	1	Nursing Home Admi		
	unwitnessed fall i	n his room on 12/12/13, and did whensive follow up fall		5. <u>Date of Completion</u> :	<u>1/28/14</u>	
• .	assessment.			Addendum to # 3. Res	uts will	
	The admission M	iinimum Data Set (MDS) dated R120 had diagnosis that		be reported to t Assurance Committee	he Qua	le try se str
	included Multiple	E Sclerosis, dementia, and post The MDS indicated R120 coul	d	for onaoine complu	where or	the ·
	walk in his room staff.	with the physical assist of one		for ongoing compluing	audits	
				1/28/14 1		
	R120 was at ris	essment dated 9/10/13, indicate c for falls and had been receivin services. The discharge physica te indicated R120 remained at	9			
	high risk for falls	R120 forgot to set the				
	wheelchair brak	es, dragged the right foot when	l			1
	walking had po	or balance and required all activities of daily living.				
	Undirated R120	e dated as reviewed on 9/13, had moderate cognitive				L.
	impairment and	I was at high risk for falls. The ted the call light within reach, gr I to assist with mobility and	ab			
	repositioning, a	assist of one for ambulation and to and from meals with voice				

· . ·

· · · · ·

· ...

· · · · · •

.....

:

...

.

:

.

9:1 Jan.28.2014

•

.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X) IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245227 (X) IDENTIFICATION NUMBER: 245227 (X) IDENTIFICATION 245227 (X) IDENTIFICATION 24523 (X) IDENTIFICATION 245247			AND HUMAN SERVICES				FORM	01/14/2014 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTY, STATE, ZIP CODE 1601 ST LOUS AVENUE BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802 PREFX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY ON LIS: DEPTRICATION DEFICIENCIES) (EACH DEFICIENCY) ID PREFX PROVIDERS AND OF CORRECTION DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DOULTH, MN 55802 F 323 Continued From page 34 commands and navigation cues from staff. The care plan dated 10/15/13, noted an alarm on the bathroom door. F 323 The undated nursing assistant assignment sheet indicated R120 was confused and needed supervision and assist of one with the wheeled walker for all ambulation. The assignment sheet indicated R120 was not injured when found on the floor between his bed and the bath room at 4:40 a.m. R120 stated he was trying to g to the bath room. The suggested interventions were to leave bathroom light on to the bathroom and the addition of a personal alarm and pressure alarm. The progress notes dated 12/12/13, at 12/12/13, at 13.8 .m. indicated R120's sheets were were tangled up in a ball on the floor at the time of the fall. The Post Fall Huddle Investigation Worksheet dated 12/12/13, indicated that R120's Tab alarms were in use and functioning properly at the time of the fall. The inconsistent reports. In addition the care plan indicated there was an alarm on the bathroom door that was not addressed in the report.	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			-		
Baryshore RESIDENCE & REHAB CTR 1601 ST LOUIS AVENUE DVALUE, Your Structure RESIDENCE & REHAB CTR DULUTH, MN 55802 DVALUE, SUMARY STATEMENT OF DEFICIENCIES RECULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX COSS.REFERENCE to THE APPROPRIATE DMART DEFICIENCY F 323 Continued From page 34 commands and navigation cues from staff. The care plan dated 10/16/13, noted an alarm on the bathroom door. F 323 The undated nursing assistant assignment sheet indicated R120 was confused and needed supervision and assist of one with the wheeled walker for all ambulation. The assignment sheet indicated R120 was not injured when found on the floor between his bed and the bath room at 44.0 a.m. R120 Stated to the was trying to go to the bathroom job to the bathroom and the addition of a personal alarm and pressure alarm. The progress notes dated 12/12/13, at all on the floor at the time of the fail. The Post Fail Huddle Investigation Worksheet dated 11/21/21, indicated that R120 ba and main a ball on the floor at the time of the fail. The Post Fail Huddle Investigation Worksheet dated 11/21/21, indicated there was an alarm on the bathroom door that was not additensed in the report.			245227	B. WING	;		12/	19/2013
DULUTH, MN 55802 OULUTH, MN 55802 OULUTH, MN 55802 OULUTH, MN 55802 PREFIX FAG F 323 Continued From page 34 commands and navigation cues from staff. The care plan dated 10/16/13, noted an alarm on the bathroom door. The undated nursing assistant assignment sheet indicated R120 was confused and needed supervision and assist of one with the wheeled walker for all ambulation. The assignment sheet indicated staff were to walk R120 to and from all meals. The Resident Incident Report dated 12/12/13, at 6:30 a.m. indicated R120 was not injured when found on the floor between his bed and the bath room at 4:40 a.m. R120 stated the was trying to go to the bathroom doil be bathroom and the addition of a personal alarm and pressure alarm. The progress notes dated 12/12/13, at 10:33 a.m. indicated R120's sheets were were tangled up in a ball on the floor at the time of the fall. The Post Fall Huddle Investigation Worksheet dated 12/12/13, indicated thar R120's Tab alarms were in use and functioning properly at the time of the fall. The inconsistent reports in addition the care plan indicated there was an alarm on the bathroom door that was not addites was not indicated there was an alarm on the bathroom door that was not addites and indicated there was an alarm on the bathroom door that was not addites was not indicated there was an alarm on the bathroom door that was not addites was not indicated there was an alarm on the bathroom door that was not addites was not indicated there was an alarm on the bathroom door that was not addites was not indicated there was an alarm on the bathroom door that was not addites was not indicated there was an	NAME OF F	PROVIDER OR SUPPLIER						
Mail Trad Predict Destriction of Null Destriction of Nul	BAYSHO	RE RESIDENCE & RI	EHAB CTR					
commands and navigation cues from staff. The care plan dated 10/16/13, noted an alarm on the bathroom door. The undated nursing assistant assignment sheet indicated R120 was confused and needed supervision and assist of one with the wheeled walker for all ambulation. The assignment sheet indicated staff were to walk R120 to and from all meals. The Resident Incident Report dated 12/12/13, at 6:30 a.m. indicated R120 was not injured when found on the floor between his bed and the bath room at 4:40 a.m. R120 stated he was trying to go to the bath room. The suggested interventions were to leave bathroom light on to improve visibility with ambulation to the bathroom and the addition of a personal alarm and pressure alarm. The progress notes dated 12/12/13, 110:38 a.m. indicated R120's sheets were were tangled up in a ball on the floor at the time of the fall. The Post Fall Huddle Investigation Worksheet dated 12/12/13, indicated that R120's Tab alarms were in use and functioning properly at the time of the fall. The inconsistent reports regarding alarms was not identified in the reports. In addition the care plan indicated there was an alarm on the bathroom dor that was not addressed in the report.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	1	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
indicated R120 was confused and needed supervision and assist of one with the wheeled walker for all ambulation. The assignment sheet indicated staff were to walk R120 to and from all meals. The Resident Incident Report dated 12/12/13, at 6:30 a.m. indicated R120 was not injured when found on the floor between his bed and the bath room at 4:40 a.m. R120 stated he was trying to go to the bath room. The suggested interventions were to leave bathroom light on to improve visibility with ambulation to the bathroom and the addition of a personal alarm and pressure alarm. The progress notes dated 12/12/13, at 10:38 a.m. indicated R120's sheets were were tangled up in a ball on the floor at the time of the fall. The Post Fall Huddle Investigation Worksheet dated 12/12/13, indicated that R120's Tab alarms were in use and functioning properly at the time of the fall. The inconsistent reports. In addition the care plan indicated there was an alarm on the bathroom door that was not addressed in the report.	F 323	commands and na care plan dated 10	vigation cues from staff. The	F	323			
6:30 a.m. indicated R120 was not injured when found on the floor between his bed and the bath room at 4:40 a.m. R120 stated he was trying to go to the bath room. The suggested interventions were to leave bathroom light on to improve visibility with ambulation to the bathroom and the addition of a personal alarm and pressure alarm. The progress notes dated 12/12/13, at 10:38 a.m. indicated R120's sheets were were tangled up in a ball on the floor at the time of the fall. The Post Fall Huddle Investigation Worksheet dated 12/12/13, indicated that R120's Tab alarms were in use and functioning properly at the time of the fall. The inconsistent reports regarding alarms was not identified in the reports. In addition the care plan indicated there was an alarm on the bathroom door that was not addressed in the report.		indicated R120 wa supervision and as walker for all ambu indicated staff were	s confused and needed sist of one with the wheeled lation. The assignment sheet					
dated 12/12/13, indicated that R120's Tab alarms were in use and functioning properly at the time of the fall. The inconsistent reports regarding alarms was not identified in the reports. In addition the care plan indicated there was an alarm on the bathroom door that was not addressed in the report.		6:30 a.m. indicated found on the floor room at 4:40 a.m. go to the bath roor were to leave bath visibility with ambu addition of a perso The progress note indicated R120's s	A R120 was not injured when between his bed and the bath R120 stated he was trying to n. The suggested interventions room light on to improve lation to the bathroom and the nal alarm and pressure alarm. s dated 12/12/13, at 10:38 a.m. heets were were tangled up in				•	
O 40/40/40 Devistand Numer (DN) E added a		dated 12/12/13, in were in use and fu of the fall. The ince alarms was not ide addition the care p alarm on the bathr	dicated that R120's Tab alarms inctioning properly at the time onsistent reports regarding entified in the reports. In olan indicated there was an room door that was not				•	
On 12/13/13, Registered Nurse (RN)-F added a Image: constraint of the incident report indicating there would be a night light added. RN-F was interviewed on Image: constraint of the incident report indicating there would be a night light added. RN-F was interviewed on FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GQM311 Facility ID: 00589 If continuation sheet Page 35		note to the incider be a night light ad	nt report indicating there would ded. RN-F was interviewed on	311	E~	acility ID: 00589		t Page 35 of 5'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XM PEROMEMUSPHUERULA DEMTIFICATION NUMBER D21 MULTIFILE CONSTRUCTION A BUILDING XM PORCE DEMTIFICATION NUMBER AME OF PROVIDER OR SUPPLIER 245227 E. WING STREET ADDRESS CTY, STATE, ZIP CODE 1601 ST LOUIS AVENUE 12/19/2013 MARE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (ACM) DEFICIENCIES STREET ADDRESS CTY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DEFICIENCIES DEFICIENCIES (%1) PERETX TAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES CONTRECTION STORE DEFICIENCIES) D PRETX TAB PRETX (EACH DEFICIENCIES CONTRECTION STORE DEFICIENCIES) D PRETX TAB PRETX (EACH DEFICIENCIES CONTRECTION STOLE DE EACH DEFICIENCIES CONTRECTION STOLE DE EACH DEFICIENCE AT THE ANALYSIS (EACH DEFICIENCE) ANALYSIS (EACH DEFICIENCE AT THE ANALYSIS (EACH DEFICIENCE) ANALYSIS (EACH DEFICIENCE) ANALYSIS (EACH DEFICIENCE AT THE ANALYSIS (EACH DEFICIENCE) ANALYSIS (EACH DEFICIENCE) ANALYSIS (EACH DEFICIENCE) ANALYSIS (EACH DEFICIENCE) (EACH DEFICIENCE)			AND HUMAN SERVICES				FORM	01/14/2014 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BAYSHORE RESIDENCE & REHAB CTR Identified and state and st				1				
1601 ST LOUIS AVENUE DULTY, MN 5802 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG D D F 323 Continued From page 35 12/19/13, at 5:00 p.m. regarding the inconsistencies of R120's fall information and analysis. RN-F stated that she set R120 to see the physical therapist; but that had not been done. RN-F stated she did not think alarms would be effective for R120. RN-F stated there was no night light in R120's room. F 323 R120 was observed on 12/18/13, at 9:30 a.m. in bed with his feet hanging over the end of the bed. The facilities Fail Prevention policy was dated September 2010. It indicated under, "Expected Outcomes" of following this policy included, that fail prevention strategies would be implemented. The second expected outcome included that interventions would be implemented on the the resident's care plan. On 12/19/13, at 5:15 p.m., the director of nursing verified the inconsistencies in the incident report after each fall and interventions would be noted on the the resident's care plan. F 325 433.25(0) MAINTAIN NUTRITION STATUS SS=D UNLESS UNAVOIDABLE F 325 433.25(0) MAINTAIN NUTRITION STATUS resident - (1) Maintains acceptable parameters of nutritional			245227	B. WING			12/	19/2013
BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802 (04.1)D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCEDE WY TULL REGULATORY OF LISC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY Comment CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY F 323 Continued From page 35 12/19/13, at 5:00 p.m. regarding the Inconsistencies of R1202's fail information and analysis. RN-F stated that she set R120 to see the physical therapist; but that had not been done. RN-F stated she did not think alarms would be effective for R120. RN-F stated there was no night light in R120's room. F 323 R120 was observed on 12/18/13, at 9:30 a.m. in bed with his feet hanging over the end of the bed. The facilities Fail Prevention policy was dated September 2010. It indicated under, "Expected Outcomes:" of following this policy included, that fail prevention strategies would be implemented. The second expected outcome included that interventions would be implemented. F On 12/19/13, at 5:15 p.m., the director of nursing verified the inconsistencies in the incident report after each fail and interventions. F On 12/19/13, at 5:15 p.m., the director of nursing verified the inconsistencies in the incident report after each fails follow-up documentation. F F 325 483.26(I) MAINTAIN NUTRTION STATUS F Ssept UNLESS UNAVOIDABLE F Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	NAME OF F	PROVIDER OR SUPPLIER	•					
PREERV TVG CEACH CORRECTIVE ACTION SHOLLD BE DEFICIENCY (US IS DEPTRIVING INFORMATION) PREERV TVG CEACH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMPLETIVE DEFICIENCY F 323 Continued From page 35 12/19/13, at 5:00 p.m. regarding the inconsistencies of R120's fall information and analysis. RN-F stated that she set R120 to see the physical therapist; but that had not been done. RN-F stated she did not think alarms would be effective for R120. RN-F stated there was no night light in R120's room. F 323 R120 was observed on 12/18/13, at 9:30 a.m. in bed with his feet hanging over the end of the bed. The facilities Fall Prevention policy was dated September 2010. It indicated under, "Expected Outcomes." of following this policy included, that fall prevention strategies would be implemented. The second expected outcome included that interventions would be implemented promptly after a fall and a post-fall analysis would be completed with 24 hours by a registered nurse after each fall and interventions would be noted on the the resident's care plan. F 325 On 12/19/13, at 5:15 p.m., the director of nursing verified the inconsistencies in the incident report and falls follow-up documentation. F 325 F 325 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintatins acceptable parameters of nutritional F 325	BAYSHO	RE RESIDENCE & RE	EHAB CTR					
12/19/13, at 5:00 p.m. regarding the inconsistencies of R120's fall information and analysis. RN-F stated that she set R120 to see the physical therapist but that had not been done. RN-F stated that she set R120 to see the flow of R120. RN-F stated there was no night light in R120's room. R120 was observed on 12/18/13, at 9:30 a.m. in bed with his feet hanging over the end of the bed. The facilities Fall Prevention policy was dated September 2010. It indicated under, "Expected Outcomes." of following this policy included, that fall prevention strategies would be implemented. The second expected outcome included that interventions would be implemented promptly after a fall and a post-fall analysis would occurs by the interdisciplinary team to help determine causes of falls and to prevent further falls. The policy indicated a "Post Fall Analysis would be completed with 24 hours by a registered nurse after each fall and interventions would be noted on the the resident's care plan. On 12/19/13, at 5:15 p.m., the director of nursing verified the inconsistencies in the incident report and falls follow-up documentation. F 325 F3325 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional F 325	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
after each fall and interventions would be noted on the the resident's care plan. On 12/19/13, at 5:15 p.m., the director of nursing verified the inconsistencies in the incident report and falls follow-up documentation. F 325 483.25(i) MAINTAIN NUTRITION STATUS SS=D UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 323	12/19/13, at 5:00 p inconsistencies of analysis. RN-F stat the physical therap done. RN-F stated be effective for R12 night light in R120's R120 was observe bed with his feet ha The facilities Fall P September 2010. If Outcomes:" of follo fall prevention strat The second expect interventions would after a fall and a po by the interdisciplin causes of falls and policy indicated a "	.m. regarding the R120's fall information and ted that she set R120 to see ist; but that had not been she did not think alarms would 20. RN-F stated there was no s room. d on 12/18/13, at 9:30 a.m. in anging over the end of the bed. revention policy was dated t indicated under, "Expected owing this policy included, that tegies would be implemented. ted outcome included that d be implemented promptly ost-fall analysis would occurs nary team to help determine to prevent further falls. The Post Fall Analysis would be	F	323	DEFICIENCY)		
SS=D UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional		on the the resident On 12/19/13, at 5: verified the inconsi and falls follow-up	's care plan. 15 p.m., the director of nursing stencies in the incident report documentation.	F	2015			
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GQM311 Facility ID: 00589 If continuation sheet Page 36 of 5	SS=D	UNLESS UNAVOII Based on a resider assessment, the fa resident - (1) Maintains acce status, such as boo	DABLE nt's comprehensive acility must ensure that a ptable parameters of nutritional dy weight and protein levels,	,		•		

and the second second

PARTI	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			. 0	<u>MB NO. C</u>	PPROVED 1938-0391
EMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE COMP	
PLAN OF							0/0040
		245227	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	12/1	9/2013
IE OF P	ROVIDER OR SUPPLIER				DI ST LOUIS AVENUE		
YSHO	RE RESIDENCE & R	EHAB CTR			ILUTH, MN 55802		
(4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) Completion Date
- 325	Continued From pa	age 36	F	325			
020	unless the residen	t's clinical condition this is not possible; and					
	(2) Receives a the nutritional problem	rapeutic diet when there is a			F <u>325</u>	- 1	
					1. Corrective Action:		
•					a R 22 tube feeding	BROR D	110
	This REQUIREME	ENT is not met as evidenced			increased from 3 cc/hr to 250 cc/h		
	by: Resed on observ:	ation, interview, and document			placed on weekly		
	review, the facility	failed to identify, assess and			weights.	•	
	address significar	it weight loss for 2 of 3 22) reviewed for nutrition. This			b. R 35 care plan w	ill be	
	resulted in actual	harm for R22.			reviewed and pla	aced	
					on weekly weigh		
	Findings include:				2. Corrective Action as it a	pplies	
	Findings melaee.				to other residents:		
		n et de l'annuis broin			100% audit of all resider		1
	R22's diagnoses	list included anoxic brain sistent vegetative state.			significant weight gain o	or loss.	
	damage and pers	istent vegenatio enter			3. <u>Reoccurrence will be</u>		
					prevented by:		
	R22's quarterly	Ainimum Data Set (MDS) dated ed R22 was totally dependent in			a. All residents on	tube .	
	all activities of da	ally living (ADL's) to include			feeding and/or		
	leafing The 11/1	5/13, MDS specified R22 had a			nutritional risk		
	feeding tube and	had no weight loss; however the	3		placed on weel	сıy	
	MDS.	alue was not documented on the		•	weights.	- 4- 6-	
					b. Weekly weight	s to be	•
	•	N	2		obtained by	ra aidac	
	The Nutritional S	Status Assessment dated 2/13/13 as at nutritional risk due to	' [·		restorative nui		
	reliance on othe	rs to administer tube feedings			c. Dietician, Unit		
	related to being	in a vegetative state. The			Manager, and		
	2/13/13 assess	ment noted R22 weighed 149			review weekly at IDT meeting		
		nothing by mouth), and received			at IUT meenny Facility ID: 00589 lf conti	nuation she	et Page 37
RM CM	S-2567(02-99) Previous Ver	sions Obsolete Event 10. Gui	01311	•			-

Jan.28.2014 6:01PM

	MENT OF HEALTH	AND HUMAN SERVICES		· · ·	FORM	01/14/2014 APPROVED 0938-0391
ATEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245227	B. WING	STREET ADDRESS, CITY, STATE, ZIP C		19/2013
	ROVIDER OR SUPPLIER			1601 ST LOUIS AVENUE	JODE	
3aysho	RE RESIDENCE & R			DULUTH, MN 55802 PROVIDER'S PLAN OF CO	PRECTION	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	
F 325		age 37	F 32	5		
	via feeding tube. indicated R22's es to 1836 kcal with the physician orde	c per hour four times per day The 2/13/13, assessment timated caloric need was 1564 54 grams of protein; however, ered Jevity 1.5 provided only ay and 76 grams of total protein		4. <u>The Correction will</u> <u>monitored by:</u> Don, Dietician, and Managers with ove Nursing Home Adr	l Unit ersight by	
	on 6/2/13; 145 lbs and 134 lbs on 12 documented weig 12/13/13. On 12 registered dieticia stated R22 weigh	/ indicated R22 weighed 149 lbs on 9/30/13; 150 lbs on 10/5/13 2/13/13. There was no ht between 10/5/13 and /19/13, at 2:45 p.m. the on/dietary director (RD/DD)-C ed 131 lbs on 12/18/13, weight loss (12.9%) in 75 days	91 	5. <u>Date of Completio</u> Addendum to #3. R be reported to the Assurance Committe for angoing comp need for angoing	<u>n: 1/28/14</u> Cesults Will Quality Cep to asse	ess the
	11/18/13, identifie assessment, indi feeding to meet PEG (percutaned tube due to anox vegetative state. lack of a current	nutrition progress note dated ed as a quarterly nutrition cated R22 continued on tube 100% of nutritional needs via bus endoscopic gastrostomy) ic brain damage and persistent The progress note verified the weight value and indicated R22 stable in the past.		need for ongoing 1/28/14 7	audits -	
	nutritional risk du via PEG tube du vegetative state plan included a of 140 lbs + or -	sed 8/19/13, indicated R22 was ue to 100% of nutrition needs m ie to anoxia brain damage, , and NPO status. R22's care goal R22 would maintain weigh 5 lbs with interventions to inclu abs and weights as ordered.				
	Dhunicipa's orde	ers dated 11/26/13, directed R2	2			

Jan.28.2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·				E SURVEY PLETED
		245227	B. WING			12/	19/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			01 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	Continued From pa	-	F	325			
	was NPO and was Liquid, 230 cc ente maintenance.	to receive Jevity 1.5 Cal rally four times a day for health					
	(RN)-G was observ Jevity 1.5 feeding p disposable gloves, flushed the tubing v tubing connected to hanging on a meta RN-G pressed the Kangaroo pump ar set at 70cc/hr inste checked the physic tube feeding admir hour. RN-G reset t RN-G, interviewed stated she talked v (LPN) working with regarding the Kang cc/hr. The LPN ve to 70 cc per hour a and confirmed the cc per hour. There the feeding pump I or if R22 had actua amount of Jevity 1 On 12/18/13, at 12 R22's weight of 13 been assessed. C RD/DD-C stated re	17 a.m. registered nurse yed to administer R22 the per PEG tube. RN-G applied checked tube placement, with water and inserted the p a bottle of the Jevity solution I pole near R22's bedside. "on" button located on R22's nd noted the administration rate ead of 230 cc/hr. RN-G cian's order and confirmed the nistration rate was 230 cc per he feeding pump to 230 cc/hr. on 12/19/13, at 12:37 p.m., with the licensed practical nurse n R22 on the previous shift garoo pump being set at 70 erified the pump rate had reset as a result of being unplugged rate should have been at 230 was no indication of how long had been set at the lower rate ally been provided the correct .5.					
		ber for the quarterly review.					

Event ID: GQM311

Facility ID: 00589

If continuation sheet Page 39 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY PLETED
		245227	B. WING			12/	19/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 325	policy provided was indicated weights s on-going basis for t weight changes an reviewed by the reg to calculate signific (7.5%) and a 6 (10) R35 was not provid related to an unpla 9.5% in 90 days. R35's diagnoses in chronic airway obs chronic pancreatitis difficile. The quarterly MDS had moderately im decision making. T required extensive eating, had no swa loss, and was on a therapeutic diet. R35's care plan re	n the facility on 12/19/13. The s dated 12/19/13, and hould be tracked on an the purpose of assessing d monthly weights would be gistered dietician each month ant change over 1 (5%), 3		32			
	therapeutic diet an uneaten at meals. adequate nutrition within 5% of 125 p meals and accept Interventions for R	k due to factors such as a ad leaves 25% or more of food R35's goal was to maintain al status by maintaining weight bounds, consuming 75% of all >75% of supplements. R35 included the following: is nce tray is set up, and					

Facility ID: 00589

If continuation sheet Page 40 of 52

	1997 - 1997 -				an a	
		AND HUMAN SERVICES			FORM	: 01/14/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA1	TE SURVEY MPLETED
		245227	B. WING		12	/19/2013
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STAT		
BAYSHO	RE RESIDENCE & RE	EHAB CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 325	RD/DD-C to evalua recommendations a orders signed 11/1/ carbohydrate diet (age 40 ate and make diet change as needed. The physician's (13 directed a consistent diabetic diet) with 3 grams ature and regular consistency	F 32	5		
	"WEIGHT WARNIN loss over 30 days, 90 days. On 11/22/ progress note that was on a mechanic averaging 25%. A r stopped due to R33 was 105 pounds, tr problems. The prog dietician would mod	rogress notes indicated NG." R35 had a 5.0% weight and a 7.5% weight loss over 13, RD/DD-C entered a indicated the following: R35 cal soft texture diet, with intake nutritional supplement was 5's dislike, and R35's weight rending down due to medical gress note further indicated the nitor R35's weight monthly and anges. R35's record lacked any gress notes.				
		indicated R35 weighed 115 lbs s on 10/5/13 and 105 lbs on				
	eating his lunch me consisted of spagh beans, a breadstick approximately 6 ou feed himself, and t approximately 2 ou	12 p.m. R35 was observed eal in his room. The meal etti, two meatballs, green k, a piece of cake and inces of milk. R35 was able to ook a few bites of cake and inces of milk. At 12:26 p.m. done and asked to lie down.				
	On 12/19/13 at 1:4	2 p.m. RD/DD-C was				
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: GQM3	11	Facility ID: 00589	If continuation shee	t Page 41 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/14/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEÝ PLETED
		245227	B. WING _		12/	19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325 F 333 SS=D	interviewed and sta nutritional supplem she discontinued it. average meal intak month of Decembe half of November 5 November, and 25- RD/DD-C stated sh foods for R35. RD/ received on 11/21/ weight loss is comr weekly during the in (IDT)meetings. RD loss was not addre last two months. 483.25(m)(2) RESI SIGNIFICANT MEI The facility must er any significant meo This REQUIREME by: Based on docume	ited R35 had been on a ent, but he was not taking it so RD/DD-C further stated R35's e was 25-50% of meals for the r, 25% of meals for the last 0-100% of meals for middle of 50% of meals in October. The did not provided fortified DD verified the weight warning I3, and stated significant nunicated to nursing staff interdisciplinary team /DD-C stated R35's weight ssed at IDT meetings for the DENTS FREE OF DERRORS Insure that residents are free of lication errors. NT is not met as evidenced int review, the facility failed to ents (R113) was free from a	F 32	<u>F 333</u> 1. <u>Corrective Action:</u> R 113's medication error discovered 8/20/13 and omitted medication star Physician was updated of 8/21/13 with no new ord Resident suffered no adv effects. 2. <u>Corrective Action as it appendix</u>	ed. n ders. verse <u>oplies</u> rs and ough a n final it ager or s	
	hemiplegia, cerebr deep vein thrombo	included history of stroke with ovascular disease, history of sis and long term use of edications that reduce the to clot).		procedure of al telephone orde consults, and P on-site orders. b. All licensed sta medical record	rs, hysician ff,	

.

...

.

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU				0938-0391 SURVEY		
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:					PLETED		
		245227	B. WING			12/19/2013			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
BAYSHO	RE RESIDENCE & RE	EHAB CTR			01 ST LOUIS AVENUE JLUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
F 333	Continued From pa	ge 42	F	333			L		
	to the facility on 8/3 discontinue warfari and to start aspirin signed off the order however, the order initiated until 8/20/1	as hospitalized, and returned b/13, with physician orders to in (anticoagulant medication) 81 milligrams daily. The facility rs as completed on 8/21/13; ed dose of aspirin was not 3, missing a total of 16 doses. notified on 8/21/13, and gave			HUC's will be in serviced on new procedure. c. Ongoing Order Transcription audits all new physician orders and results w be reported to the				
		e completed due to no staff t the facility were working at lication error.			Quality Assurance Committee quarter to assess for ongoin compliance and the	ng			
F 441 SS=F	consequences and directed a medicat - a drug is ordered 483.65 INFECTION SPREAD, LINENS The facility must en Infection Control P safe, sanitary and	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission		441	need for further audits. 4. <u>The Correction will be</u> <u>monitored by:</u> DON, Unit Managers, and designees with oversight by Nursing Home Administrate 5. <u>Date of Completion: 1/28/</u>	or			
	Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied	stablish an Infection Control							

·

. 1 a - 444

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		245227	B. WING			12/	19/2013	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
BAYSHO	RE RESIDENCE & RE	EHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 441	determines that a r prevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each d hand washing is in professional practif (c) Linens Personnel must hat transport linens so infection. This REQUIREME by: Based on observa- review the facility f infection control pr tracking employee employees on the and procedure and is following the fac and procedures. T potential to effect staff failed to follow	Anfections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must a prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. at require staff to wash their irect resident contact for which dicated by accepted ce. andle, store, process and as to prevent the spread of ENT is not met as evidenced ation, interview and document tailed to have an effective rogram related to lack of a illness, training new facility infection control policies d surveillance to ensuring staff cility infection control policies this deficient practice had the all 126 residents In addition w proper infection control 1 residents (R34) in droplet	F	441	 <u>F 441</u> <u>Corrective Action:</u> COTA-A will be re-educate contact and droplet isolati precautions. R 34's chart medical record was review by DON, Nurse Practioner Physician. No medical necessity was found for continued isolation. Isola discontinued. <u>Corrective Action as it app</u> to other residents: a. No other resident isolation at prese time b. Human resources track employee it using a line list. c. New employees w receive training of infection control blood borne pathogens. <u>Reoccurrence will be prevented by:</u> a. Procedures revie and revised on tipe 	ion and ved , and tion <u>blies</u> ts on nt s to liness will on and		

Facility ID: 00589

If continuation sheet Page 44 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		CONSTRUCTION		E SURVEY PLETED
		245227	B. WING			12/	19/2013
NAME OF I	PROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHC	RE RESIDENCE & R	EHAB CTR			01 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa Findings include:	age 44	F 4	141			
	(COTA)-A failed to protective equipme hygiene when worl active MethicIlin-re (MRSA) infection. R34's diagnoses in tracheostomy (surg opening through th [windpipe]). A nursing note data to) infection risk ar caregivers, NP (nu	ional therapy assistant wear appropriate personal ent (PPE) and perform hand king with R34 who had an sistant Staphylococcus aureus include MRSA pneumonia and gical procedure to create an ie neck into the trachea ed 11/7/13 indicated, d/t (due ad safety to [R34] and all his irse practitioner) wants [R34] to echniques in place with supplies om.		-	of employee infections. b. All facility staff w in serviced on inf control procedur including types of isolation, hand washing, and employee illness c. New employee p and procedure reviewed and re to include infect control and bloc borne pathogen d. All departments	ection es f oolicy vised ion d s.	-
	wear gowns, mask the residents room On 12/17/13 at 10 outside R34's roor	:05 a.m. a sign was noted n indicating contact and droplet	t.		updated of any resident on isola precautions to i reason for isolat and type of isola	ntion nclude ion	
	isolation precautions. A cart outside the room contained PPE (gowns, gloves and facial masks). A certified occupational therapy assistant (COTA)-A was in R34's room wearing mask, but not wearing gloves or a gown. R34 was observed in the bed. COTA was next to the bed as she removed R34's cushion from a wheelchair and placed it in a plastic bag. COTA-A then attempted to dispense hand sanitizer from a wall mount container in the resident's room; however, the container was empty. COTA-A did not wash her				needed. e. DON or infectio control nurse to employee line li least weekly. f. Hand washing a staff with return demonstration.	o review st at udits of n	

		AND HUMAN SERVICES				FORM A	01/14/2014 PPROVED)938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMPI	
		245227	B. WING			12/1	9/2013
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa hands prior to leavi	-	F	441			
	COTA-A was intervindicated R34 had she did not glove a providing direct car COTA-A verified th was empty and tha prior to leaving R34 At 10:15 a.m. a reginterviewed and sta to a respiratory infe didn't know what the On 12/18/13 at 1:5 (DON) verified that gown and gloves whave washed her DON further indicat have a lack of com RN-B didn't know winfection was. Whe facility's procedures they are employing practices DON ind a facility system at random audits of the The facility Type a Required for Infect dated 2007 directed precautions within	riewed at that time and MRSA in his nares and nd gown because she was not re to the resident. e hand sanitizer in the room it she didn't wash her hands 4's room. gistered nurse (RN-B) was ated R34 was in isolation due ection. RN-B further stated she			 g. Results of audits w be reported to the Quality Assurance Committee to asse for ongoing compliance and the need for further audits. 4. The Correction will be <u>monitored by:</u> DON, Infection Control Nur Unit Managers, and design with oversight by Nursing Home Administrator. 5. Date of Completion: 1/28/ FULL Review employ UNE USEE I east week I east week As that end What Week Boot and as and boot a boot Boot a boot Boot	ss - e rse, ees / <u>14</u>	
FORM CMS-	2567(02-99) Previous Version	ns Obsolete Event ID: GQM	 311	Fa	acility ID: 06วอง การอานานส	tion sneet	⊷age 46 of 52

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	-		(3) DATE	0938-0391 SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:						COM	PLETED
		245227	B. WING					12/1	9/2013
NAME OF F	ROVIDER OR SUPPLIER	,			T ADDRESS, CIT		CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			JTH, MN 5580				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×		'S PLAN OF CO ECTIVE ACTION ENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 441	Continued From pa	ge 46	F4	41					
(system to track em	ion control program lacked a ployee illness and to ensure re trained for appropriate ocedures.							
	p.m. regarding the program. The DON procedure for track stated. "I have bee heard of any system illness-obviously th because I should k human resources of information regardididn't know what the	viewed on 12/18/13, at 2:00 facility infection control I stated there was no policy or ing employee illness. DON n here a month I have not m of tracking employee ey must not be tracking it now." DON further stated the department gets the ng employee illness, but she ey did with the information.							
		regarding tracking of as requested but not provided.							
	how new employee control or blood bo DON provided the orientation evaluat	ted she was not sure what or es are being trained in infection rne pathogens At 2:30 p.m. facility new employee ion checklist and stated, "I see	2						
F 465 SS=F	here." 483.70(h) SAFE/FUNCTION	oorne pathogens) training on AL/SANITARY/COMFORTABL	F4	465			·		
		rovide a safe, functional, ortable environment for d the public.							
		NT is not met as evidenced							

.

CENTER STATEMENT AND PLAN C	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER RE RESIDENCE & RE	TEMENT OF DEFICIENCIES	A. BUILDIN B. WING ID	STREET ADDRESS, CITY, STATE, ZIP 1601 ST LOUIS AVENUE DULUTH, MN 55802 PROVIDER'S PLAN OF C	FORM OMB NO. (X3) DATE COM 12/ CODE	01/14/2014 APPROVED 0938-0391 E SURVEY PLETED 19/2013
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	DATE
F 465	by: Based on observa review the facility fa rooms were mainta homelike manner fa R125, R13, R1, R1 R102, R143, R81, veneer on doors at wallpaper, and und and floors. Findings include: The facility lacked environmental issu On 12/18/13 at 2:0 tour with the main two of the houseke the following was r Rehab Unit R182's room had a veneer, the bathro scratched. The gr covered with foam had a uncleanable R125's room had a veneer, the bathro scratched. The h had an area appro loose metal. MM-/ needed repair. R13's room had a	tion interview and document ailed to ensure that resident ained in a sanitary and or 14 of 126 residents (R182, 65, R18, R138, R40, R126, R76, R55) related to broken and drawers, missing or peeling clean surfaces in bathrooms a system to identify and repair res in resident rooms. 00 p.m. during an environmental tenance manager (MM)-A and eeping staff (HK)-A and (HK)-B noted; a built-in dresser with missing om door was marred and rab bar in the bathroom was a. HK-A verified the grab bar	F 46	 55 <u>F 465</u> <u>Corrective Action</u> The facility will m resident rooms to sanitary and hom environment. Th identified during will be assessed accordingly. <u>Corrective Action to other resident The facility will c audit of all reside repairs and reno necessary.</u> <u>Reoccurrence w prevented by:</u> The facility utiliz system for Preve Maintenance an communication potential mainte problems. The I dept. will be in s identify potenti communicate th to Maintenance 	haintain o preserve a helike he items the survey and renovated <u>n as it applies</u> ts: complete an ent rooms for wate as <u>ill be</u> tes a TELS entative housekeeping serviced to al repairs and hat information e Dept. during	

		AND HUMAN SERVICES		· .	FORM A	PPROVED 938-0391
ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE COMPI	
		245227	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12/1	9/2013
IAME OF P	ROVIDER OR SUPPLIER			1601 ST LOUIS AVENUE		
BAYSHO	RE RESIDENCE & R	EHAB CTR		DULUTH, MN 55802		125
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE.	(X5) CDMPLETION DATE
F 465	Continued From p	age 48	F 41	65		
	Morning Light Uni	t	-	The Maintenance Dept. divided the facility into	5	-
	wallpaper above to long by six inches base of the toilet spots. MM-A verific replaced and that surface. R165's room door handle and on the verified they were bathroom door at scuffs marks. R18's bathroom base of the toilet R138's room hat four inches long bed	d an area of torn and missing he sink approximately one foot is wide. The caulk around the was not intact and had black ied the caulk needed to be the area was not a cleanable r had Velcro on the inside e wall behind the door. HK-A e uncleanable surfaces. The nd missing veneer and black had missing caulk around the d an area approximately four by of missing drywall above the hat a cable box had been in that		sections and will comple environmental tour to document every resider is observed on a weekly 4. <u>The Correction will be</u> <u>monitored by:</u> Maintenance and Housekeeping during r walking rounds. 5. <u>Date of Completion: 1</u> Addendum to # 3. Will be reported to # Quality Assurance Com to a ssess for orgoing c and ongoing audits. 1/28/14 TS	nt room y basis. outine <u>/28/14</u> Desa 145	
	R40 had a mattr bed. The mattre approximately 2 foam. MM-A sta away!" R126's room ha the bathroom d area with a rag the hinges. The bathroom door	ress as a floor mat next to the ss vinyl cover had a tear in it feet long resulting in exposed ted, "That needs to be thrown d black areas next to hinges on oor. HK-A was able to wipe the and indicated it was grease from base board to the right of the had an area approximately six was pulled away from the wall.		and ongoing audits. 1/28/14 TS	•	

Jan.28.2014

.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING	;		12/1	19/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	intact. The plastic li was cracked. MM-/ repairs. R102 and R143's re- inside handle that w The duct tape was parts of the adhesis door was dented at privacy curtain nex substance area app inch. The bathroom black scuffs. HK-A be washed and the R81's room had br corner of the bathro- eight inches by ei floor was missing t bathroom light fixtu approximately six i didn't know what the was but verified the be replaced Park Breeze unit R76's room had 2 the bed. R76's quad dated 9/6/13 identi cognition,. When a indicated he didn't there when he mov- ago. R55's room had two	he base of the toilet was not ght fixture in the bathroom A verified the room need oom door had Velcro on the was covered with duct tape. rolled up in a ball exposing ve side. The wall behind the nd had missing drywall. The t to R143's bed had brown proximately six inches by one n door had missing veneer and verified the curtain needed to a room needed repairs. rown water stains on the com ceiling approximately ght inches size. The bathroom hree tiles near the toilet. The ure had a crack in it nches long. MM-A indicated he he brown area on the ceiling a tile and light fixtures need to gouges in the drywall behind arterly minimum data set (MDS) fied R76 as having intact usked about the gouges R76 cause the gouges, they were yed into the facility three years		465			
	her bed and the bu	uilt in dresser had missing and					

Facility ID: 00589

If continuation sheet Page 50 of 52

		AND HUMAN SERVICES				FORM	01/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245227	B. WING	i		12/	19/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR			601 ST LOUIS AVENUE DULUTH, MN 55802		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	Continued From pa chipped veneer.	age 50	F	465			
	not have an ongoir program specificall	ng the tour that the facility did ng preventive maintenance y for residents room. MM-A expect staff to tell him of repair.					
	indicated the facilit called TELS that a areas within the fa- to yearly for preven	30 p.mthe administrator y used a computer program lerts maintenance of what cility to review every two weeks ntive maintenance. Review of the TELS screen did not oms.					
	The facility failed to the small refrigerat	o ensure cleanable surfaces in tor in the kitchen.					
	noon with the food shelves of the sma metal racks that w shelves contained service. The shelv	salads in individuals bowls that					
		policy dated 2010 indicated units are kept clean and in dition at all times.					-
	12:00 p.m. that sh	lirector stated on 12/16/13, at e knew that a new cooler was med the rusted selves were not					

Facility ID: 00589

If continuation sheet Page 51 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/14/2014 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED	
		245227	B. WING	;		- 12/19/2013		
NAME OF F	PROVIDER OR SUPPLIER	L		STR	EET ADDRESS, CITY, STATE, ZIP C			
BAYSHO	RE RESIDENCE & RE	EHAB CTR			1 ST LOUIS AVENUE LUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 465	Continued From pa cleanable.	ge 51	F	465				
					, 1			
	,							
<i></i>								
FORM CMS-2	567(02-99) Previous Version:	s Obsolete Event ID: GQI		Facilit	ty ID: 00589 If	continuation shee	Page 52 of 52	

If continuation sheet Page 52 of 52

)(12/20/2013
	MENT OF HEALTH			F	5227023		APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA	(X2) MULTI	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	JRVEY
		245227		B. WING		12/18	3/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
BAYSHC	ORE RESIDENCE &	REHAB CTR		r Louis a' H, MN 55			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCI	ES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	(FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	JLD BE	COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	Minnesota Departm time of this survey, found in substantia requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing Bayshore Health Ce a no basement. The constructed in 1969 original building buil Type II (111) constr was inspected as of The building is fully facility has a comple smoke detection in that is monitored for notification. The fac 140 beds and had a the survey. The requirement at MET.	at 42 CFR, Subpart by from Fire, and the Fire Protection Assoc 01, Life Safety Code Health Care. enter is a 2-story built original building wa with an addition in digs and additions uction, therefore, the ne building. fire sprinkler protect ete fire alarm system spaces open to the or automatic fire depa ility has a licensed c a census of 126 at th 42 CFR Subpart 483	At the nter was e 2000 ciation (LSC), ding with s 1978. The are all e facility ed. The with corridor, irtment apacity of e time of 3.70(a) is	NATURE	TITIF		(X6) DATE
LABORATOR	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	NTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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