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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245227**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1821433426**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE RESIDENCE & REHAB CTR**
(L4) **1601 ST LOUIS AVENUE**
(L5) **DULUTH, MN** (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
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2013**

6. DATE OF SURVEY **04/23/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **139** (L18)

13.Total Certified Beds **139** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	139			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, HFE NEII — 05/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 06/09/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/22/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/28/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Mark 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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing	4/23/2014

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 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	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **03/19/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/19/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/19/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/19/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	05/22/2014	29433	March 19, 2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2013				

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245227**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1821433426**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE RESIDENCE & REHAB CTR**
(L4) **1601 ST LOUIS AVENUE**
(L5) **DULUTH, MN** (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**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2013** **03/06/2014** **(L&C HFC)**

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **139** (L18)

13.Total Certified Beds **139** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	139			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 04/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/18/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/22/1979 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
02/28/2014 (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5227

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 standardy 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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

REVISED

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 tho 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: 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.

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing	3/6/2014

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 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0162** Reg. # **483.10(c)(8)** LSC	**01/28/2014**	ID Prefix **F0170** Reg. # **483.10(i)(1)** LSC	**01/28/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	**01/28/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**01/28/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**01/28/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**01/28/2014**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	**01/28/2014**	ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	**01/28/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**01/28/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PH	03/22/2014	29433	03/06/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing	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 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0309 Reg. # 483.25 LSC	01/28/2014	ID Prefix F0333 Reg. # 483.25(m)(2) LSC	01/28/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/KL	Date: 03/22/2014	Signature of Surveyor: 28595	Date: 03/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/13/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R-C 03/06/2014

RECEIVED APR 07 2014 MN Dept of Health Duluth

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An investigator from OHFC completed an investigation for complaint number H5227047. the complaint was substantiated with one example included with F157. In addition, a follow up was completed for deficiencies issued subsequent to complaint H5227042 with F333 corrected and F314 reissued. Census 147.	{F 000}	OIC 4-8-14 PLH This plan of correction constitutes Bayshore Residence and Rehabilitation Center's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	**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 legal 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 a decision to transfer or discharge the resident from the facility.	

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

Mike Bosley | Administrator | 4/4/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and the resident's representative were notified in the change of status of a pressure ulcer for 1 of 3 residents (R171) reviewed for pressure ulcers and for 1 of 1 residents (R180) reveiwed for respiratory distress. Findings include: R171's Diagnosis Report dated 3/6/14, indicated diagnoses including cerebrovascular disease. The quarterly Minimum Data Set (MDS) dated 1/29/14, indicated R171 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 or greater pressure ulcer present on admission, 2 unstageable pressure ulcers, with eschar present, 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 had a scab on the left ankle bone.	F 157	1. Corrective Action: a. R 171 ulcers were assessed and 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 relates to notification of change and the necessity to notify the healthcare provider. 2. Corrective Action as it applies to other Residents: a. An audit was done of residents who had perceived or actual changes in condition that should be reported to the healthcare provider. b. Concurrent review will be done 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 of changes that should be reported to the provider/resident's legal representative and/or interested family member.	

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F 157	Continued From page 2 An Initial Skin Problem Identification Assessment 1/13/14, indicated R171's left ankle had a loose scab measuring 1.4 cm by 1.9 cm. and a discolored purple area measuring 1.4 cm by 2.0 cm. on the left heel. The fax physician's order dated 1/14/14, directed Solosite to scab, cover with gauze and wrap with Kerlix daily and reassess after scab comes off for different treatment. R171's Care Plan dated and revised 11/8/13, indicated an unstageable pressure ulcer on left outer ankle with 100% eschar. The Care Plan directed to follow facility protocols for treatment of skin injury and to notify physician for orders as needed, monitor/document location, size, and treatment of skin injury, report abnormalities, failure to heal signs and symptoms of infection, maceration to MD. Hand-written notes on the Care Plan dated 12/26/13, directed Allevyn [an adhesive, wound care dressing] per MD orders. A Skin Ulcer Data Collection and Assessment form dated 2/25/14, indicated R171's left ankle ulcer had healed. On 3/5/14, at 7:10 a.m. registered nurse (RN)-C was observed during treatment of R171's left ankle ulcer. RN-C stated the ulcer opened on 3/4/14, when the scab fell off. RN-C measured the ulcer at 0.5 cm by 0.6 cm. RN-C applied a clean Curad dressing to ulcer wound area, covered the Curad dressing with a 4 by 4 inch gauze dressing and wrapped the ankle and dressing with a rolled gauze dressing taping the wrap in place. On 3/5/14, at 7:11 a.m. RN-B stated she did not notify the physician or R171's family when the	F 157	3. Reoccurrence will be prevented by: a. Licensed Staff will be re-trained on identification of changes that must be reported to the provider/resident's legal representative and/or interested family member. b. Daily meetings will include review of conditions that require notification of the provider/ resident's legal representative and/or interested family member related to change in condition. 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 for review. 5. Date of Completion: 3/19/14	

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F 157	Continued From page 3 ulcer re-opened. On 3/5/14, at 11:40 am, the DON stated RN-B was responsible to assess and stage ulcers. The DON further stated when the stage changed and/or the ulcer opened up, the RN would be responsible to notify the resident's physician, the resident's family, and also the dietician. A Change of Condition/Special Needs Charting policy reviewed and revised 5/2011, directed the resident's physician would be contacted in a timely manner either verbally or written if the resident experiences a change in skin integrity, not addressed through the facility's skin care protocol. The policy further directed the resident's family/significant other would be notified when there is a change in status of a resident. The facility failed to notify R180 ' s physician for change of condition regarding respiratory distress. A progress note dated 2/17/14, at 6:56 p.m. indicated R180 was calling out in pain and rated her pain 10/10 in her back. R180 ' s vital signs were taken and oxygen saturation was 73%, pulse elevated to 110. R180 ' s head of bed (HOB) was elevated, and she was instructed to pierce-lip breath. R180 also received Roxenol (narcotic used for pain) for breathing difficulties, [the] sharp pain in [her] back decreased as sat [oxygen saturation] rose. [R180] Will be monitored on 24 hour report and vitals rechecked for improvement.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 4 A progress note dated 2/18/14, at 6:08 a.m. indicated that resident was in respiratory distress, given 0.3 milligrams of MS Sulfate (Morphine Sulfate) per supervisor request, resident calmed self, with pursed lip breathing, oxygen saturation level [was] at 92%, heart rate was up 112 due to nebulizer just being given, continue to monitor, resident to be on four hour vital sign checks. A progress note dated 2/18/14, indicated that St. Luke ' s emergency room (ER) called stating, they will be keeping resident overnight with diagnosis of Carbon Dioxide retention and new diagnosis of pneumonia. Resident was sent out for a scheduled appointment and was referred to St. Luke ' s ER. R180 was admitted on 12/9/13, with diagnoses that included acute chronic obstructive pulmonary disease (COPD). The care plan dated 12/20/13, had a focus area of altered respiratory status that included interventions to observed for sign/symptoms of respiratory distress and report to the MD (medical doctor) PRN (as needed) per protocol. NA-H was interviewed on 3/4/14, at 3:00 p.m. NA-H reported that R-180 had told her several times in the previous two weeks that she didn ' t feel good and felt foggy. NA-H reported these concerns to the LPN on duty at the time of the complaints and the LPN did go and talk with R180. The nurses that NA-A reported to were LPN-A, and LPN-B. R180 was interviewed on 3/4/14, at 3:10 p.m. R180 was asked what happened on 2/18/14, the day she was hospitalized. R180 stated that she was scheduled to go to a therapy appointment at the development center. R180 stated that she arrived at the center and her therapist saw her and after a short time the therapist suggested that R180 go to the emergency room. R180	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 5 stated that she was having a lot of trouble breathing, was having difficulty staying awake and answering the therapist ' s questions, couldn ' t focus on what the therapist was saying and requested to go to the hospital. R180 was taken to the emergency room by the Medi-Van that had transported her to the appointment. R180 stated that she was admitted to the Intensive Care Unit with a diagnosis of acute exacerbation of Chronic Obstructive Pulmonary Disease (COPD) with acute hyper-capnic respiratory failure. R180 was then asked about the days leading up to the hospitalization. R180 stated that she was very groggy, clumsy with things like dropping spoons and her nebulizer. R180 stated that she was in a fog all the time. R180 reported that she felt like this for at least one week before being hospitalized. R180 stated that she was having more difficulty breathing. R180 stated that she felt so bad that she had requested to go to the hospital several times but they wouldn ' t send her. R180 stated that she reported these symptoms to the LPN ' s and they would come to her room and talk but nothing was done, " they didn ' t call my MD " , and nurses wouldn ' t respond when she asked to go to the hospital. R180 stated that she was afraid because she felt so horrible and nobody would listen. R180 stated that the night before the hospitalization (2/17/14) she was very sick and in a lot of pain, she said she was short of breath, pulse was high and she couldn ' t find a position that was comfortable. She stated that she asked LPN-A to send her to the hospital but LPN-A never provided her an explanation as to why R180 was not sent to the hospital. An interview of LPN-A was completed on 3/4/14, at 3:20 p.m. LPN-A was asked what steps she takes when a resident has a change in condition.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 6 LPN-A stated that she will go to the resident and do vital signs, see if they have PRN treatments or medications that could be tried, after that LPN-A will call the supervisor if there is no change. LPNA recalled an incident with R180 that occurred on 2/17/14, the night before R180 was hospitalized. R180 became short of breath, complained of back pain, her oxygen sat level was 72% and her pulse was 110. LPN-A contacted RN-E to report the symptoms and report that the resident is requesting to go to the hospital and LPN-A would consult with the MD. RN-E stated that R180 was drug seeking and to just watch her. LPN-A reports that the resident did stabilize however LPN-A didn ' t agree with the drug seeking behavior and felt R180 was ill. An interview of the director of nursing (DON) was completed on 3/4/14, at 4:30 p.m. The DON was asked what the expectation of the LPN/RN ' s are when a resident ' s condition changes. The DON stated that the facility expects the nurse to do a complete assessment prior to calling the physician, the LPN or RN ' s are able to call the MD ' s and the LPN ' s can take telephone orders. The DON expected the physician would be called when a patient ' s condition changes. The evening and night staff have a nursing supervisor on duty to consult with if there are any questions. In regards to R180 ' s change in condition; the daily reports the DON receives regarding what happens on evenings and night shift didn ' t address R180 ' s condition or concerns. An interview of trained medication aide (TMA-A) was completed on 3/6/14, at 11:25 a.m. TMA-A recalled an incident involving R180 that occurred on 2/17/14, at approximately 7:00 - 7:30 p.m. R180 was in a lot of distress on that shift, R180 requested to go to the hospital, LPN-C went into assess R180 LPN-C called RN-E and reported	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 7 back to TMA-A that RN-E felt R180 was drug seeking behavior and to watch the resident. TMA-A reported that the MD was not called at that time. Interview of RN-E was completed on 3/7/14, at 11:35 a.m. RN-E was asked what her involvement with R180 ' s care on 2/17/14, the evening before R180 was hospitalized. RN-E reported that she recalled hearing about the situation but does not recall any specifics or how she heard about it. RN-E was asked if she called the MD regarding R180 or if the nursing unit was to call the MD. RN-E did not know if the MD called. RN-E stated that she did not go to the unit to see R180 and that she did not know R180 that well. RN-E indicated that she does not keep notes or a log of calls she received while she is supervising. RN-E does not recall ever telling a staff not to call an MD. RN-E stated she would have documented in the electronic medical record progress notes if she felt it was a significant event. When asked further information about R180 and if she was a drug seeker, RN-E indicated that she had heard that information from other staff and did not provide any other information to indicate a reason that R180 was a drug seeker. Interview of R180 ' s mental health therapist (MHT) was completed on 3/18/14, at 8:30 a.m. R180 was scheduled to see her MHT on 2/18/14, in the afternoon. The therapist stated that R180 has been a client with her for approximately five years. The MHT was asked what symptoms R180 had when she arrived to the appointment. The MHT stated that R180 ' s breathing difficulties had been getting worse over the last three months, however, not as bad as she saw on 2/18/14. R180 was very short of breath, had labored breathing and she complained of being	F 157		

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	245227	A. BUILDING _____ B. WING _____	R-C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 157	Continued From page 8 weak. R180 was having difficulty focusing on the conversation, there were delays in responding to questions of up to 30 seconds and she was dozing off during the conversation. The MHT stated that R180 told her that she has been sick for at least a week and that she was getting worse. R180 told the MHT that she had reported her concerns to the nursing staff at the facility several times but they didn ' t do anything and that she had asked to go to the hospital but they didn ' t think she needed to go. The Change in Condition/Special Needs Charting Policy (revision date May 2011) was reviewed. The policy purpose directed staff to: Notify the physician, next of kin, designated contact person or significant other in the event of a status change. The policy further directed staff to monitor changes of condition and interventions to be documented.	F 157		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 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. Findings include: R181 was not provided timely repositioning for a	{F 282}	**F 282** It is the practice of this facility to ensure the services provided or arranged by the facility shoule be provided by qualified persons in accordance with each resident's written plan of care. 1. Corrective Action: R 181's and R 171's care plans were reviewed. The issue related 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 adaptive equipment including booties are in place to relieve pressure.	

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{F 282}	Continued From page 9 stage 2 (partial thickness loss of dermis presenting as shallow open ulcer) coccyx pressure ulcer. R181's admission Minimum Data Set (MDS) dated 12/20/13, indicated R181 was severely cognitively impaired, and required extensive assist of 2 staff for bed mobility and transfers, and extensive assist of one staff for toileting. The MDS further indicated R181 was at risk for the development of a pressure ulcer, and currently had a stage 2 pressure ulcer. R181's care plan, dated 12/19/13, indicated R181 was admitted with a stage 2 pressure ulcer on the coccyx and directed staff assistance significant repositioning in bed and when in wheelchair every two hours, and as needed. R181 was not provided repositioning during continuous observation on 3/4/14, from 9:56 a.m. until 12:55 p.m.. At 1:01 p.m. NA-B put R181 into bed. RN-B measured R181's pressure ulcer as 2.4 cm x 4 cm, and stated it was a stage II. On 3/4/14, at 2:37 p.m. the director of nursing (DON) stated that every two hours would be minimal, some residents may require more frequent repositioning if the pressure ulcer was getting worse, or if the resident was experiencing pain. The DON further stated she would expect staff to reposition residents as directed by their care plan. The facility policy and procedure on pressure ulcers revised 5/11, directed residents with impaired skin integrity receive treatment according to a standard protocol that meets standards of practice. The policy and procedure	{F 282}	2. Corrective Action as it applies to other Residents: a. An audit of residents to ensure those that need repositioning on a scheduled basis are identified and actions taken to assure this activity is occurring. b. An audit of resident care plans and group sheets whom require repositioning and/or device applications to ensure that this activity is occurring, as wee as adding appropriate interventions as needed. 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 application of special devices will be checked to assure that this activity is occurring as listed on the care plans and group sheets.	

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{F 282}	Continued From page 10 further directed skin care is provided in accordance with physician's orders. The facility staff provide skin care according to a standard protocol which has been approved by the facility's medical director and is included in the standing orders. The facility policy and procedure on comprehensive care plans revised 10/10, directed each resident's comprehensive care plan is designed to aid in preventing or reducing declines in the resident's functional status and/or functional levels. R171 was not consistently provided pressure-relieving devices for a left lateral heel ulcer; in addition the left lateral heel ulcer was not assessed or treated as directed by facility standing orders or physician orders. The quarterly MDS dated 1/29/14, indicated R171 was at risk for the development of pressure ulcers, had a stage 1 or greater pressure ulcer present on admission, 2 unstageable pressure ulcers, with eschar present, and had pressure reducing devices on the chair and bed. An Initial Skin Problem Identification Assessment 1/13/14, indicated R171's left ankle was noted to have a loose scab measuring 1.4 cm by 1.9 cm. The Assessment also indicated R171's left heel had a discolored purple area measuring 1.4 cm by 2.0 cm. The Care Plan dated and revised 11/8/13, indicated R171 had an unstageable pressure ulcer on left outer ankle with 100% eschar that was present on admission to the facility with treatment of Allevyn [adhesive wound care	{F 282}	c. Items will be 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 for review. 5. Date of Completion: 3/19/14	

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{F 282}	Continued From page 11 dressing] per MD orders. The Care Plan directed to follow facility protocols for treatment of skin injury and to notify physician for orders as needed, monitor/document location, size, and treatment of skin injury, report abnormalities, failure to heal signs and symptoms of infection, maceration to MD. The Care Plan further directed R171 needed assistance to apply bilateral heel protectors. Physician's orders dated 1/14/14, directed Solosite to scab, cover with gauze and wrap with Kerlix daily and reassess after scab comes off for different treatment. A Skin Ulcer Data Collection and Assessment form dated 2/25/14, indicated R171's left ankle ulcer had healed. On 3/5/14, at 7:10 a.m. registered nurse (RN)-C was observed during a dressing change to R171's left ankle. The dressing was removed and RN-C stated the left ankle ulcer had reopened on 3/4/14, when the scab had fallen off. RN-C measured the ulcer at 0.5 cm by 0.6 cm., applied a clean Curad dressing, added a 4 by 4 inch gauze dressing and wrapped the ankle and dressing with rolled gauze. RN-C applied a brown slipper to R171's left foot. One of R171's quilted blue booties was lying on the dresser and the other on the bedside table. R171's right heel was observed to be resting on the bed with only a white sock on the right foot. On 3/5/14, at 8:00 a.m., R171's left lateral ankle ulcer was observed with RN-B. RN-B removed the brown slipper shoe and the dressing on R171's left foot/ankle. RN-B measured the ulcer, applied a Curad dressing, a 4 by 4 inch gauze	{F 282}		

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{F 282}	Continued From page 12 and gauze wrap. RN-B stated the left lateral ankle ulcer was stage 2. RN-B confirmed the physician and family were not notified when the pressure ulcer reopened on 3/4/14. RN-B stated she changed R171's ulcer treatment to a vaseline dressing daily with dry gauze. RN-B did not apply R171's left blue-quilted heel boot. On 3/5/14, at 9:45 a.m. the DON and RN-B were interviewed. RN-B stated she was unaware of any standing orders for wound care. RN-B further stated when R171's healed left lateral ankle ulcer re-opened, she decided on a different treatment based on her wound care experience. RN-B further stated she does not usually contact the nurse practitioner or the physician with a change of orders when an ulcer opens up. RN-B verified R171's ulcer treatment was changed to a vaseline-type dressing and R171's physician was not notified of the change in condition of the ulcer and there was no physician's order to change the treatment. On 3/5/14, at approximately 10:45 a.m. R171 was observed seated in wheelchair in hallway near nurses' station wearing white stockings and brown slipper shoes. On 3/5/14, at 11:40 am, the DON was re-interviewed and stated RN-B was required to assess and stage ulcers. The DON further stated when the stage changes and/or the ulcer opened up, the RN would be responsible to notify the resident's physician, the resident's family, and also the dietician. The DON confirmed she would expect the ulcers to be monitored and assessed weekly and the results documented either on the weekly skin sheet or in the progress notes. The DON stated the facility had standing orders and a	{F 282}		

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{F 282}	Continued From page 13 protocol to cover ulcer care changes. The DON stated R171's left lateral ankle ulcer would be stage 2 when the scab/eschar fell off. The DON confirmed she was not made aware of R171's ulcer opening up until this morning.	{F 282}	**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 services to promote healing, prevent infection and prevent new sores from developing. 1. Corrective Action: R 181's and R 171's care plans were reviewed. The issue related 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 adaptive equipment including booties are in place to relieve pressure.	
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that 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 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care of pressure ulcers for 2 of 3 residents (R181, R171) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed,	{F 314}		

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{F 314}	Continued From page 14 without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined. R181 was not provided timely repositioning for a stage 2 coccyx pressure ulcer. R181's admission record indicated diagnosis of Alzheimer's disease, generalized pain and osteoporosis. The admission Minimum Data Set (MDS) dated 12/20/13, indicated R181 was severely cognitively impaired, and required extensive assist of 2 staff for bed mobility and transfers, and extensive assist of one staff for toileting. The MDS further indicated R181 was at risk for the development of a pressure ulcer, and currently had a stage 2 pressure ulcer. R181's care plan, dated 12/19/13, indicated R181 was admitted with a stage 2 pressure ulcer on the coccyx and directed staff assistance significant repositioning in bed and when in wheelchair every two hours, and as needed. Although the nursing assistant group sheet directed staff to check and offer toileting every two hours and as needed, repositioning was not addressed. R181 was continuously observed on 3/4/14, from 9:56 a.m. until 12:55 p.m.. R181 was observed in	{F 314}	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 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.	

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{F 314}	Continued From page 15 an activity, then toileted by staff from 10:10 a.m. until 10:22 a.m. R181 was brought back into the activity room and and then to the dining room at 11:40 a.m. R181 was served lunch at 12:11 p.m., and finished feeding herself at 12:49 p.m. At 12:52 p.m., R181 had been in the wheelchair without repositioning for 2 hours and 30 minutes. Registered nurse (RN)-B and nursing assistant (NA)-B were informed of R181's lack of repositioning and R181 was wheeled to the bedroom at 12:54. p.m.. NA-B stated she was on the way to the dining room to get R181 and knew R181 required every two hour repositioning. At 1:01 p.m. NA-B put R181 into bed. RN-B measured R181's pressure ulcer as 2.4 cm x 4 cm, and stated it was a stage 2. On 3/4/14, at 2:37 p.m. the director of nursing (DON) and RN-B were interviewed. RN-B stated she directed all dependent residents to have an every two hour repositioning plan. The DON stated that every two hours would be minimal, some residents may require more frequent repositioning if the pressure ulcer was getting worse, or if the resident was experiencing pain. The DON further stated she would expect staff to reposition residents as directed by their care plan. The facility policy and procedure on pressure ulcers revised 5/11, directed residents with impaired skin integrity receive treatment according to a standard protocol that meets standards of practice. The policy and procedure further directed skin care is provided in accordance with physician's orders. The facility staff provide skin care according to a standard protocol which has been approved by the facility's medical director and is included in the standing orders.	{F 314}	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 for review. 5. Date of Completion: 3/19/14	

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{F 314}	Continued From page 16 R171 was not consistently provided pressure-relieving devices for a left lateral heel ulcer; in addition the left lateral heel ulcer was not assessed or treated as directed by facility standing orders or physician orders. A Diagnosis Report dated 3/6/14, indicated R171's diagnoses included cerebrovascular disease. The quarterly MDS dated 1/29/14, indicated R171 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 or greater pressure ulcer present on admission, 2 unstageable pressure ulcers, with eschar present, 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. An Initial Skin Problem Identification Assessment 1/13/14, indicated R171 had an ulcer and a bruise. The Assessment further indicated R171's left ankle was noted to have a loose scab measuring 1.4 cm by 1.9 cm. The Assessment also indicated R171's left heel had a discolored purple area measuring 1.4 cm by 2.0 cm. R171's Care Plan dated and revised 11/8/13,	{F 314}		

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{F 314}	Continued From page 17 indicated actual impairment to skin integrity related to an abrasion to the left outer leg, left elbow, left hip, scabbed areas to the left knee, and several scabs to lower legs and left outer ankle. The Care Plan note dated 12/26/13, indicated R171 had an unstageable pressure ulcer on left outer ankle with 100% eschar that was present on admission to the facility with treatment of Allevyn [adhesive wound care dressing] per MD orders. The Care Plan directed to follow facility protocols for treatment of skin injury and to notify physician for orders as needed, monitor/document location, size, and treatment of skin injury, report abnormalities, failure to heal signs and symptoms of infection, maceration to MD. The Care Plan further directed R171 needed assistance to apply bilateral heel protectors. The undated nursing assistant assignment sheet directed R171 was to have the blue boot on left heel/foot at all times. A Patient Information Fax for order requested dated 1/14/14, indicated R171 had a thick scab measuring 1.4 cm by 1.9 cm, loose and coming off on left ankle. The order requested fax further indicated the nurse was requesting and did receive orders to apply Solosite to scab, cover with gauze and wrap with Kerlix daily and reassess after scab comes off for different treatment. A Skin Ulcer Data Collection and Assessment form dated 2/25/14, indicated R171's left ankle ulcer had healed. An electronic progress note dated 2/25/14, indicated R171's left ankle area was closed, with some discoloration around the ankle, and whole area was blanchable with no	{F 314}		

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{F 314}	Continued From page 18 pain.. The progress note further indicated the area would be left open to the air. The progress note further described R171's left heel with a discolored area measuring 1.7 cm by 2.0 cm, which was blanchable and non-painful. On 3/5/14, at 7:10 a.m. registered nurse (RN)-C was observed during a dressing change to R171's left ankle. The dressing was removed and RN-C stated the left ankle ulcer had reopened on 3/4/14, when the scab had fallen off. RN-C stated R171's left lateral ankle ulcer was unstageable with a reddened wound bed and no drainage on the old dressing. RN-C measured the ulcer at 0.5 cm by 0.6 cm., applied a clean Curad dressing, added a 4 by 4 inch gauze dressing and wrapped the ankle and dressing with rolled gauze. RN-C applied a brown slipper to R171's left foot. One of R171's quilted blue booties was lying on the dresser and the other on the bedside table. R171's right heel was observed to be resting on the bed with only a white sock on the right foot. On 3/5/14, at 7:11 a.m. RN-B stated R171's left lateral ankle ulcer was unstageable. RN-B further stated she assessed the ulcer on 3/4/14, when the ulcer re-opened, but did not document or report the change. RN-B further stated R171 was to wear the quilted blue booties daily while in bed. RN-B stated R171's left heel discolored area was another pressure unstageable pressure ulcer. On 3/5/14, at 8:00 a.m., R171's left lateral ankle ulcer was observed with RN-B. RN-B removed the brown slipper shoe and the dressing on R171's left foot/ankle. RN-B measured the ulcer, applied a Curad dressing, a 4 by 4 inch gauze	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R-C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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{F 314}	Continued From page 19 and gauze wrap. RN-B stated the left lateral ankle ulcer was stage 2. RN-B confirmed the physician and family were not notified when the pressure ulcer reopened on 3/4/14. RN-B stated she changed R171's ulcer treatment to a vaseline dressing daily with dry gauze. RN-B did not apply R171's left blue-quilted heel boot. On 3/5/14, at 9:45 a.m. the DON and RN-B were interviewed. RN-B stated she was unaware of any standing orders for wound care. RN-B further stated when R171's healed left lateral ankle ulcer re-opened, she decided on a different treatment based on her wound care experience. RN-B further stated she does not usually contact the nurse practitioner or the physician with a change of orders when an ulcer opens up. RN-B verified R171's ulcer treatment was changed to a vaseline-type dressing and R171's physician was not notified of the change in condition of the ulcer and there was no physician's order to change the treatment. On 3/5/14, at approximately 10:45 a.m. R171 was observed seated in wheelchair in hallway near nurses' station wearing white stockings and brown slipper shoes. On 3/5/14, at 11:40 am, the DON was re-interviewed and stated RN-B was required to assess and stage ulcers. The DON further stated when the stage changes and/or the ulcer opened up, the RN would be responsible to notify the resident's physician, the resident's family, and also the dietician. The DON confirmed she would expect the ulcers to be monitored and assessed weekly and the results documented either on the weekly skin sheet or in the progress notes. The DON stated the facility had standing orders and a	{F 314}		

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{F 314}	Continued From page 20 protocol to cover ulcer care changes. The DON stated R171's left lateral ankle ulcer would be stage 2 when the scab/eschar fell off. The DON confirmed she was not made aware of R171's ulcer opening up until this morning. On 3/5/14, at 12:05 p.m. the DON provided a computer print out of the DeRoyal Heel Pillows indications for use. The print out indicated the heel pillows provided protection against skin breakdown, heel decubitus ulcer prevention, skin shearing and/or skin friction. The DON confirmed the heel pillow's manufacturer's indications lacked information describing the product as pressure relieving or reducing.	{F 314}		
{F 465} SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure wheelchairs were kept clean for 2 of 3 (R199, R145) residents. Findings include: On 3/3/14, at 5:22 p.m. R145's wheelchair was observed in the second floor dining room. The wheelchair had multiple old food spills on the frame, foot rests, and the seat. R145 was observed to spill multiple times while attempting	{F 465}	**F 465** It is the practice of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. Corrective Action: a. R 199's and R 145's wheelchairs were cleaned. b. Other wheelchairs were inspected for cleanliness. 2. Corrective Action as it applies to other Residents: a. The facility wheelchair cleaning schedule was reviewed to assure that no wheelchairs have been left off cleaning schedule.	

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{F 465}	Continued From page 21 to feed herself during the meal. On 3/6/14, at 1:30 p.m. R199's electric scooter type wheelchair was observed to be soiled. The foot rest, the front and back molded covering, the seat cushion and the arm rests were soiled with brown and white colored substances. The basket had dried leaves in it. R199 stated the scooter was his own and no one had offered to clean it for him. On 3/6/14, at 1:50 p.m. R145's wheelchair was observed to have food in the spokes. The black padded arm rests on both sides were cracked. At 2:00 p.m. the director of nursing (DON) observed R199's and R145's wheelchairs and verified they were soiled. The DON stated the facility had a wheelchair washer and wheelchairs were to be washed according to a schedule on the night shift. The DON stated R199 was newly admitted to the facility and R145's wheelchair was to be washed often. The Wheelchairs, Walkers and Cushions Cleaning Schedule (not dated) indicated R199's wheelchair was to be cleaned on Wednesdays. The Nursing Assistant Night Duty List dated 3/6/14, indicated R145's wheelchair was to be washed nightly.	{F 465}	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 has been 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>	

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.

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.

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

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

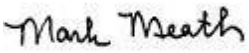
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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.

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R-C 03/06/2014

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BAYSHORE RESIDENCE & REHAB CTR	**1601 ST LOUIS AVENUE DULUTH, MN 55802**

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{F 000}	INITIAL COMMENTS An investigator from OHFC completed an investigation for complaint number H5227047. the complaint was substantiated with one example included with F157. In addition, a follow up was completed for deficiencies issued subsequent to complaint H5227042 with F333 corrected and F314 reissued. Census 147.	{F 000}		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		

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

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and the resident's representative were notified in the change of status of a pressure ulcer for 1 of 3 residents (R171) reviewed for pressure ulcers and for 1 of 1 residents (R180) reveiwed for respiratory distress. Findings include: R171's Diagnosis Report dated 3/6/14, indicated diagnoses including cerebrovascular disease. The quarterly Minimum Data Set (MDS) dated 1/29/14, indicated R171 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 or greater pressure ulcer present on admission, 2 unstageable pressure ulcers, with eschar present, 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 had a scab on the left ankle bone.	F 157		

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F 157	Continued From page 2	F 157		

An Initial Skin Problem Identification Assessment 1/13/14, indicated R171's left ankle had a loose scab measuring 1.4 cm by 1.9 cm. and a discolored purple area measuring 1.4 cm by 2.0 cm. on the left heel.

The fax physician's order dated 1/14/14, directed Solosite to scab, cover with gauze and wrap with Kerlix daily and reassess after scab comes off for different treatment.

R171's Care Plan dated and revised 11/8/13, indicated an unstageable pressure ulcer on left outer ankle with 100% eschar. The Care Plan directed to follow facility protocols for treatment of skin injury and to notify physician for orders as needed, monitor/document location, size, and treatment of skin injury, report abnormalities, failure to heal signs and symptoms of infection, maceration to MD. Hand-written notes on the Care Plan dated 12/26/13, directed Allevyn [an adhesive, wound care dressing] per MD orders.

A Skin Ulcer Data Collection and Assessment form dated 2/25/14, indicated R171's left ankle ulcer had healed.

On 3/5/14, at 7:10 a.m. registered nurse (RN)-C was observed during treatment of R171's left ankle ulcer. RN-C stated the ulcer opened on 3/4/14, when the scab fell off. RN-C measured the ulcer at 0.5 cm by 0.6 cm. RN-C applied a clean Curad dressing to ulcer wound area, covered the Curad dressing with a 4 by 4 inch gauze dressing and wrapped the ankle and dressing with a rolled gauze dressing taping the wrap in place.
On 3/5/14, at 7:11 a.m. RN-B stated she did not notify the physician or R171's family when the

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F 157	Continued From page 3 ulcer re-opened. On 3/5/14, at 11:40 am, the DON stated RN-B was responsible to assess and stage ulcers. The DON further stated when the stage changed and/or the ulcer opened up, the RN would be responsible to notify the resident's physician, the resident's family, and also the dietician. A Change of Condition/Special Needs Charting policy reviewed and revised 5/2011, directed the resident's physician would be contacted in a timely manner either verbally or written if the resident experiences a change in skin integrity, not addressed through the facility's skin care protocol. The policy further directed the resident's family/significant other would be notified when there is a change in status of a resident. The facility failed to notify R180 ' s physician for change of condition regarding respiratory distress. A progress note dated 2/17/14, at 6:56 p.m. indicated R180 was calling out in pain and rated her pain 10/10 in her back. R180 ' s vital signs were taken and oxygen saturation was 73%, pulse elevated to 110. R180 ' s head of bed (HOB) was elevated, and she was instructed to pierce-lip breath. R180 also received Roxenol (narcotic used for pain) for breathing difficulties, [the] sharp pain in [her] back decreased as sat [oxygen saturation] rose. [R180] Will be monitored on 24 hour report and vitals rechecked for improvement.	F 157		

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A progress note dated 2/18/14, at 6:08 a.m. indicated that resident was in respiratory distress, given 0.3 milligrams of MS Sulfate (Morphine Sulfate) per supervisor request, resident calmed self, with pursed lip breathing, oxygen saturation level [was] at 92%, heart rate was up 112 due to nebulizer just being given, continue to monitor, resident to be on four hour vital sign checks.
A progress note dated 2/18/14, indicated that St. Luke ' s emergency room (ER) called stating, they will be keeping resident overnight with diagnosis of Carbon Dioxide retention and new diagnosis of pneumonia. Resident was sent out for a scheduled appointment and was referred to St. Luke ' s ER.
R180 was admitted on 12/9/13, with diagnoses that included acute chronic obstructive pulmonary disease (COPD). The care plan dated 12/20/13, had a focus area of altered respiratory status that included interventions to observed for sign/symptoms of respiratory distress and report to the MD (medical doctor) PRN (as needed) per protocol.
NA-H was interviewed on 3/4/14, at 3:00 p.m. NA-H reported that R-180 had told her several times in the previous two weeks that she didn ' t feel good and felt foggy. NA-H reported these concerns to the LPN on duty at the time of the complaints and the LPN did go and talk with R180. The nurses that NA-A reported to were LPN-A, and LPN-B.
R180 was interviewed on 3/4/14, at 3:10 p.m. R180 was asked what happened on 2/18/14, the day she was hospitalized. R180 stated that she was scheduled to go to a therapy appointment at the development center. R180 stated that she arrived at the center and her therapist saw her and after a short time the therapist suggested that R180 go to the emergency room. R180

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stated that she was having a lot of trouble breathing, was having difficulty staying awake and answering the therapist ' s questions, couldn ' t focus on what the therapist was saying and requested to go to the hospital. R180 was taken to the emergency room by the Medi-Van that had transported her to the appointment. R180 stated that she was admitted to the Intensive Care Unit with a diagnosis of acute exacerbation of Chronic Obstructive Pulmonary Disease (COPD) with acute hyper-capnic respiratory failure.
R180 was then asked about the days leading up to the hospitalization. R180 stated that she was very groggy, clumsy with things like dropping spoons and her nebulizer. R180 stated that she was in a fog all the time. R180 reported that she felt like this for at least one week before being hospitalized. R180 stated that she was having more difficulty breathing. R180 stated that she felt so bad that she had requested to go to the hospital several times but they wouldn ' t send her. R180 stated that she reported these symptoms to the LPN ' s and they would come to her room and talk but nothing was done, " they didn ' t call my MD " , and nurses wouldn ' t respond when she asked to go to the hospital. R180 stated that she was afraid because she felt so horrible and nobody would listen. R180 stated that the night before the hospitalization (2/17/14) she was very sick and in a lot of pain, she said she was short of breath, pulse was high and she couldn ' t find a position that was comfortable. She stated that she asked LPN-A to send her to the hospital but LPN-A never provided her an explanation as to why R180 was not sent to the hospital.
An interview of LPN-A was completed on 3/4/14, at 3:20 p.m. LPN-A was asked what steps she takes when a resident has a change in condition.

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LPN-A stated that she will go to the resident and do vital signs, see if they have PRN treatments or medications that could be tried, after that LPN-A will call the supervisor if there is no change.
LPNA recalled an incident with R180 that occurred on 2/17/14, the night before R180 was hospitalized. R180 became short of breath, complained of back pain, her oxygen sat level was 72% and her pulse was 110. LPN-A contacted RN-E to report the symptoms and report that the resident is requesting to go to the hospital and LPN-A would consult with the MD. RN-E stated that R180 was drug seeking and to just watch her. LPN-A reports that the resident did stabilize however LPN-A didn ' t agree with the drug seeking behavior and felt R180 was ill.
An interview of the director of nursing (DON) was completed on 3/4/14, at 4:30 p.m. The DON was asked what the expectation of the LPN/RN ' s are when a resident ' s condition changes. The DON stated that the facility expects the nurse to do a complete assessment prior to calling the physician, the LPN or RN ' s are able to call the MD ' s and the LPN ' s can take telephone orders. The DON expected the physician would be called when a patient ' s condition changes. The evening and night staff have a nursing supervisor on duty to consult with if there are any questions. In regards to R180 ' s change in condition; the daily reports the DON receives regarding what happens on evenings and night shift didn ' t address R180 ' s condition or concerns.
An interview of trained medication aide (TMA-A) was completed on 3/6/14, at 11:25 a.m. TMA-A recalled an incident involving R180 that occurred on 2/17/14, at approximately 7:00 - 7:30 p.m. R180 was in a lot of distress on that shift, R180 requested to go to the hospital, LPN-C went into assess R180 LPN-C called RN-E and reported

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back to TMA-A that RN-E felt R180 was drug seeking behavior and to watch the resident. TMA-A reported that the MD was not called at that time.
Interview of RN-E was completed on 3/7/14, at 11:35 a.m. RN-E was asked what her involvement with R180 ' s care on 2/17/14, the evening before R180 was hospitalized. RN-E reported that she recalled hearing about the situation but does not recall any specifics or how she heard about it. RN-E was asked if she called the MD regarding R180 or if the nursing unit was to call the MD. RN-E did not know if the MD called. RN-E stated that she did not go to the unit to see R180 and that she did not know R180 that well. RN-E indicated that she does not keep notes or a log of calls she received while she is supervising. RN-E does not recall ever telling a staff not to call an MD. RN-E stated she would have documented in the electronic medical record progress notes if she felt it was a significant event. When asked further information about R180 and if she was a drug seeker, RN-E indicated that she had heard that information from other staff and did not provide any other information to indicate a reason that R180 was a drug seeker.
Interview of R180 ' s mental health therapist (MHT) was completed on 3/18/14, at 8:30 a.m. R180 was scheduled to see her MHT on 2/18/14, in the afternoon. The therapist stated that R180 has been a client with her for approximately five years. The MHT was asked what symptoms R180 had when she arrived to the appointment. The MHT stated that R180 ' s breathing difficulties had been getting worse over the last three months, however, not as bad as she saw on 2/18/14. R180 was very short of breath, had labored breathing and she complained of being

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F 157	Continued From page 8 weak. R180 was having difficulty focusing on the conversation, there were delays in responding to questions of up to 30 seconds and she was dozing off during the conversation. The MHT stated that R180 told her that she has been sick for at least a week and that she was getting worse. R180 told the MHT that she had reported her concerns to the nursing staff at the facility several times but they didn ' t do anything and that she had asked to go to the hospital but they didn ' t think she needed to go. The Change in Condition/Special Needs Charting Policy (revision date May 2011) was reviewed. The policy purpose directed staff to: Notify the physician, next of kin, designated contact person or significant other in the event of a status change. The policy further directed staff to monitor changes of condition and interventions to be documented.	F 157		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 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. Findings include: R181 was not provided timely repositioning for a	{F 282}		

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stage 2 (partial thickness loss of dermis presenting as shallow open ulcer) coccyx pressure ulcer.

R181's admission Minimum Data Set (MDS) dated 12/20/13, indicated R181 was severely cognitively impaired, and required extensive assist of 2 staff for bed mobility and transfers, and extensive assist of one staff for toileting. The MDS further indicated R181 was at risk for the development of a pressure ulcer, and currently had a stage 2 pressure ulcer.

R181's care plan, dated 12/19/13, indicated R181 was admitted with a stage 2 pressure ulcer on the coccyx and directed staff assistance significant repositioning in bed and when in wheelchair every two hours, and as needed.

R181 was not provided repositioning during continuous observation on 3/4/14, from 9:56 a.m. until 12:55 p.m.. At 1:01 p.m. NA-B put R181 into bed. RN-B measured R181's pressure ulcer as 2.4 cm x 4 cm, and stated it was a stage II.

On 3/4/14, at 2:37 p.m. the director of nursing (DON) stated that every two hours would be minimal, some residents may require more frequent repositioning if the pressure ulcer was getting worse, or if the resident was experiencing pain. The DON further stated she would expect staff to reposition residents as directed by their care plan.

The facility policy and procedure on pressure ulcers revised 5/11, directed residents with impaired skin integrity receive treatment according to a standard protocol that meets standards of practice. The policy and procedure

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further directed skin care is provided in accordance with physician's orders. The facility staff provide skin care according to a standard protocol which has been approved by the facility's medical director and is included in the standing orders.

The facility policy and procedure on comprehensive care plans revised 10/10, directed each resident's comprehensive care plan is designed to aid in preventing or reducing declines in the resident's functional status and/or functional levels.

R171 was not consistently provided pressure-relieving devices for a left lateral heel ulcer; in addition the left lateral heel ulcer was not assessed or treated as directed by facility standing orders or physician orders.

The quarterly MDS dated 1/29/14, indicated R171 was at risk for the development of pressure ulcers, had a stage 1 or greater pressure ulcer present on admission, 2 unstageable pressure ulcers, with eschar present, and had pressure reducing devices on the chair and bed.

An Initial Skin Problem Identification Assessment 1/13/14, indicated R171's left ankle was noted to have a loose scab measuring 1.4 cm by 1.9 cm. The Assessment also indicated R171's left heel had a discolored purple area measuring 1.4 cm by 2.0 cm.

The Care Plan dated and revised 11/8/13, indicated R171 had an unstageable pressure ulcer on left outer ankle with 100% eschar that was present on admission to the facility with treatment of Allevyn [adhesive wound care

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dressing] per MD orders. The Care Plan directed to follow facility protocols for treatment of skin injury and to notify physician for orders as needed, monitor/document location, size, and treatment of skin injury, report abnormalities, failure to heal signs and symptoms of infection, maceration to MD. The Care Plan further directed R171 needed assistance to apply bilateral heel protectors.

Physician's orders dated 1/14/14, directed Solosite to scab, cover with gauze and wrap with Kerlix daily and reassess after scab comes off for different treatment.

A Skin Ulcer Data Collection and Assessment form dated 2/25/14, indicated R171's left ankle ulcer had healed.

On 3/5/14, at 7:10 a.m. registered nurse (RN)-C was observed during a dressing change to R171's left ankle. The dressing was removed and RN-C stated the left ankle ulcer had reopened on 3/4/14, when the scab had fallen off. RN-C measured the ulcer at 0.5 cm by 0.6 cm., applied a clean Curad dressing, added a 4 by 4 inch gauze dressing and wrapped the ankle and dressing with rolled gauze. RN-C applied a brown slipper to R171's left foot. One of R171's quilted blue booties was lying on the dresser and the other on the bedside table. R171's right heel was observed to be resting on the bed with only a white sock on the right foot.

On 3/5/14, at 8:00 a.m., R171's left lateral ankle ulcer was observed with RN-B. RN-B removed the brown slipper shoe and the dressing on R171's left foot/ankle. RN-B measured the ulcer, applied a Curad dressing, a 4 by 4 inch gauze

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and gauze wrap. RN-B stated the left lateral ankle ulcer was stage 2. RN-B confirmed the physician and family were not notified when the pressure ulcer reopened on 3/4/14. RN-B stated she changed R171's ulcer treatment to a vaseline dressing daily with dry gauze. RN-B did not apply R171's left blue-quilted heel boot.

On 3/5/14, at 9:45 a.m. the DON and RN-B were interviewed. RN-B stated she was unaware of any standing orders for wound care. RN-B further stated when R171's healed left lateral ankle ulcer re-opened, she decided on a different treatment based on her wound care experience. RN-B further stated she does not usually contact the nurse practitioner or the physician with a change of orders when an ulcer opens up. RN-B verified R171's ulcer treatment was changed to a vaseline-type dressing and R171's physician was not notified of the change in condition of the ulcer and there was no physician's order to change the treatment.

On 3/5/14, at approximately 10:45 a.m. R171 was observed seated in wheelchair in hallway near nurses' station wearing white stockings and brown slipper shoes.

On 3/5/14, at 11:40 am, the DON was re-interviewed and stated RN-B was required to assess and stage ulcers. The DON further stated when the stage changes and/or the ulcer opened up, the RN would be responsible to notify the resident's physician, the resident's family, and also the dietician. The DON confirmed she would expect the ulcers to be monitored and assessed weekly and the results documented either on the weekly skin sheet or in the progress notes. The DON stated the facility had standing orders and a

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{F 282}	Continued From page 13 protocol to cover ulcer care changes. The DON stated R171's left lateral ankle ulcer would be stage 2 when the scab/eschar fell off. The DON confirmed she was not made aware of R171's ulcer opening up until this morning.	{F 282}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that 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 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care of pressure ulcers for 2 of 3 residents (R181, R171) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed,	{F 314}		

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without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.
Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined.

R181 was not provided timely repositioning for a stage 2 coccyx pressure ulcer.

R181's admission record indicated diagnosis of Alzheimer's disease, generalized pain and osteoporosis. The admission Minimum Data Set (MDS) dated 12/20/13, indicated R181 was severely cognitively impaired, and required extensive assist of 2 staff for bed mobility and transfers, and extensive assist of one staff for toileting. The MDS further indicated R181 was at risk for the development of a pressure ulcer, and currently had a stage 2 pressure ulcer.

R181's care plan, dated 12/19/13, indicated R181 was admitted with a stage 2 pressure ulcer on the coccyx and directed staff assistance significant repositioning in bed and when in wheelchair every two hours, and as needed. Although the nursing assistant group sheet directed staff to check and offer toileting every two hours and as needed, repositioning was not addressed.

R181 was continuously observed on 3/4/14, from 9:56 a.m. until 12:55 p.m.. R181 was observed in

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{F 314}	Continued From page 15	{F 314}		

an activity, then toileted by staff from 10:10 a.m. until 10:22 a.m. R181 was brought back into the activity room and and then to the dining room at 11:40 a.m. R181 was served lunch at 12:11 p.m., and finished feeding herself at 12:49 p.m. At 12:52 p.m., R181 had been in the wheelchair without repositioning for 2 hours and 30 minutes. Registered nurse (RN)-B and nursing assistant (NA)-B were informed of R181's lack of repositioning and R181 was wheeled to the bedroom at 12:54. p.m.. NA-B stated she was on the way to the dining room to get R181 and knew R181 required every two hour repositioning. At 1:01 p.m. NA-B put R181 into bed. RN-B measured R181's pressure ulcer as 2.4 cm x 4 cm, and stated it was a stage 2.

On 3/4/14, at 2:37 p.m. the director of nursing (DON) and RN-B were interviewed. RN-B stated she directed all dependent residents to have an every two hour repositioning plan. The DON stated that every two hours would be minimal, some residents may require more frequent repositioning if the pressure ulcer was getting worse, or if the resident was experiencing pain. The DON further stated she would expect staff to reposition residents as directed by their care plan.

The facility policy and procedure on pressure ulcers revised 5/11, directed residents with impaired skin integrity receive treatment according to a standard protocol that meets standards of practice. The policy and procedure further directed skin care is provided in accordance with physician's orders. The facility staff provide skin care according to a standard protocol which has been approved by the facility's medical director and is included in the standing orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R-C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 16	{F 314}		

R171 was not consistently provided pressure-relieving devices for a left lateral heel ulcer; in addition the left lateral heel ulcer was not assessed or treated as directed by facility standing orders or physician orders.

A Diagnosis Report dated 3/6/14, indicated R171's diagnoses included cerebrovascular disease.

The quarterly MDS dated 1/29/14, indicated R171 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 or greater pressure ulcer present on admission, 2 unstageable pressure ulcers, with eschar present, 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.

An Initial Skin Problem Identification Assessment 1/13/14, indicated R171 had an ulcer and a bruise. The Assessment further indicated R171's left ankle was noted to have a loose scab measuring 1.4 cm by 1.9 cm. The Assessment also indicated R171's left heel had a discolored purple area measuring 1.4 cm by 2.0 cm.

R171's Care Plan dated and revised 11/8/13,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R-C 03/06/2014

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{F 314}	Continued From page 17	{F 314}		

indicated actual impairment to skin integrity related to an abrasion to the left outer leg, left elbow, left hip, scabbed areas to the left knee, and several scabs to lower legs and left outer ankle. The Care Plan note dated 12/26/13, indicated R171 had an unstageable pressure ulcer on left outer ankle with 100% eschar that was present on admission to the facility with treatment of Allevyn [adhesive wound care dressing] per MD orders. The Care Plan directed to follow facility protocols for treatment of skin injury and to notify physician for orders as needed, monitor/document location, size, and treatment of skin injury, report abnormalities, failure to heal signs and symptoms of infection, maceration to MD. The Care Plan further directed R171 needed assistance to apply bilateral heel protectors.

The undated nursing assistant assignment sheet directed R171 was to have the blue boot on left heel/foot at all times.

A Patient Information Fax for order requested dated 1/14/14, indicated R171 had a thick scab measuring 1.4 cm by 1.9 cm, loose and coming off on left ankle. The order requested fax further indicated the nurse was requesting and did receive orders to apply Solosite to scab, cover with gauze and wrap with Kerlix daily and reassess after scab comes off for different treatment.

A Skin Ulcer Data Collection and Assessment form dated 2/25/14, indicated R171's left ankle ulcer had healed. An electronic progress note dated 2/25/14, indicated R171's left ankle area was closed, with some discoloration around the ankle, and whole area was blanchable with no

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	245227	A. BUILDING _____ B. WING _____	R-C 03/06/2014

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BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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{F 314}	Continued From page 18	{F 314}		

pain.. The progress note further indicated the area would be left open to the air. The progress note further described R171's left heel with a discolored area measuring 1.7 cm by 2.0 cm, which was blanchable and non-painful.

On 3/5/14, at 7:10 a.m. registered nurse (RN)-C was observed during a dressing change to R171's left ankle. The dressing was removed and RN-C stated the left ankle ulcer had reopened on 3/4/14, when the scab had fallen off. RN-C stated R171's left lateral ankle ulcer was unstageable with a reddened wound bed and no drainage on the old dressing. RN-C measured the ulcer at 0.5 cm by 0.6 cm., applied a clean Curad dressing, added a 4 by 4 inch gauze dressing and wrapped the ankle and dressing with rolled gauze. RN-C applied a brown slipper to R171's left foot. One of R171's quilted blue booties was lying on the dresser and the other on the bedside table. R171's right heel was observed to be resting on the bed with only a white sock on the right foot.

On 3/5/14, at 7:11 a.m. RN-B stated R171's left lateral ankle ulcer was unstageable. RN-B further stated she assessed the ulcer on 3/4/14, when the ulcer re-opened, but did not document or report the change. RN-B further stated R171 was to wear the quilted blue booties daily while in bed. RN-B stated R171's left heel discolored area was another pressure unstageable pressure ulcer.

On 3/5/14, at 8:00 a.m., R171's left lateral ankle ulcer was observed with RN-B. RN-B removed the brown slipper shoe and the dressing on R171's left foot/ankle. RN-B measured the ulcer, applied a Curad dressing, a 4 by 4 inch gauze

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{F 314}	Continued From page 19	{F 314}		

and gauze wrap. RN-B stated the left lateral ankle ulcer was stage 2. RN-B confirmed the physician and family were not notified when the pressure ulcer reopened on 3/4/14. RN-B stated she changed R171's ulcer treatment to a vaseline dressing daily with dry gauze. RN-B did not apply R171's left blue-quilted heel boot.

On 3/5/14, at 9:45 a.m. the DON and RN-B were interviewed. RN-B stated she was unaware of any standing orders for wound care. RN-B further stated when R171's healed left lateral ankle ulcer re-opened, she decided on a different treatment based on her wound care experience. RN-B further stated she does not usually contact the nurse practitioner or the physician with a change of orders when an ulcer opens up. RN-B verified R171's ulcer treatment was changed to a vaseline-type dressing and R171's physician was not notified of the change in condition of the ulcer and there was no physician's order to change the treatment.

On 3/5/14, at approximately 10:45 a.m. R171 was observed seated in wheelchair in hallway near nurses' station wearing white stockings and brown slipper shoes.

On 3/5/14, at 11:40 am, the DON was re-interviewed and stated RN-B was required to assess and stage ulcers. The DON further stated when the stage changes and/or the ulcer opened up, the RN would be responsible to notify the resident's physician, the resident's family, and also the dietician. The DON confirmed she would expect the ulcers to be monitored and assessed weekly and the results documented either on the weekly skin sheet or in the progress notes. The DON stated the facility had standing orders and a

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{F 314}	Continued From page 20 protocol to cover ulcer care changes. The DON stated R171's left lateral ankle ulcer would be stage 2 when the scab/eschar fell off. The DON confirmed she was not made aware of R171's ulcer opening up until this morning. On 3/5/14, at 12:05 p.m. the DON provided a computer print out of the DeRoyal Heel Pillows indications for use. The print out indicated the heel pillows provided protection against skin breakdown, heel decubitus ulcer prevention, skin shearing and/or skin friction. The DON confirmed the heel pillow's manufacturer's indications lacked information describing the product as pressure relieving or reducing.	{F 314}		
{F 465} SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure wheelchairs were kept clean for 2 of 3 (R199, R145) residents. Findings include: On 3/3/14, at 5:22 p.m. R145's wheelchair was observed in the second floor dining room. The wheelchair had multiple old food spills on the frame, foot rests, and the seat. R145 was observed to spill multiple times while attempting	{F 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 465}	Continued From page 21	{F 465}		

to feed herself during the meal.

On 3/6/14, at 1:30 p.m. R199's electric scooter type wheelchair was observed to be soiled. The foot rest, the front and back molded covering, the seat cushion and the arm rests were soiled with brown and white colored substances. The basket had dried leaves in it. R199 stated the scooter was his own and no one had offered to clean it for him.

On 3/6/14, at 1:50 p.m. R145's wheelchair was observed to have food in the spokes. The black padded arm rests on both sides were cracked.

At 2:00 p.m. the director of nursing (DON) observed R199's and R145's wheelchairs and verified they were soiled. The DON stated the facility had a wheelchair washer and wheelchairs were to be washed according to a schedule on the night shift. The DON stated R199 was newly admitted to the facility and R145's wheelchair was to be washed often.

The Wheelchairs, Walkers and Cushions Cleaning Schedule (not dated) indicated R199's wheelchair was to be cleaned on Wednesdays.

The Nursing Assistant Night Duty List dated 3/6/14, indicated R145's wheelchair was to be washed nightly.

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

AH Form Approved
3/24/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00589	A. Building B. Wing	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	01/28/2014	ID Prefix 21545 Reg. # MN Rule 4658.1320 A.B.C LSC	01/28/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/KL	03/24/2014	28595	03/07/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/13/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245227**
2.STATE VENDOR OR MEDICAID NO.
(L2) **1821433426**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE RESIDENCE & REHAB CTR**
(L4) **1601 ST LOUIS AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2013**

6. DATE OF SURVEY **12/19/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **140** (L18)

13.Total Certified Beds **140** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	140			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 01/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/22/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
52280
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

Remedies - 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;

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

Informal Dispute Resolution - 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	12/19/2013

RECEIVED
JAN 27 2014
MN Dept of Health
Duluth

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (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. 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. Census 126 An investigation of complaint H5227042 was completed. The complaint was substantiated with deficiencies issued at tags F333 and F314.	F 000	OK as revised 1-29-14 PLN Disclaimer: Preparation and/or execution of this plan of correction does not constitute admissions or agreements by the provider of the 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 it 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.	
F 162 SS=D	483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers	F 162		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Bailey	Administrator	1/24/14

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

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F 162	Continued From page 1 who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this subpart. Dietary services as required at §483.35 of this subpart. An activities program as required at §483.15(f) of this subpart. Room/bed maintenance services. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at §483.15(g) of this subpart. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: Telephone.	F 162	F 162 1. Corrective Action: The facility will provide information on covered and non-covered Medicaid costs upon admission. 2. Corrective Action as it applies to other residents: Medicaid residents will receive a copy of the policy regarding services or items covered under the Medicaid contract 3. Reoccurrence will be prevented by: Newly admitted residents will receive a copy of the services or items covered under the Medicaid contract upon admission to the facility. 4. The Correction will be monitored by: Social Services and Business Office 5. Date of Completion: 1/28/14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 162	Continued From page 2 Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal clothing. Personal reading matter. Gifts purchased on behalf of a resident. Flowers and plants. Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart. The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 1 of 1 family members (FM)-1 information on covered and non-covered	F 162	Addendum to #4. When admission packet placed in financial file, visual check that copy of file in place. Results will be reported to the Quality Assurance committe to assess for ongoing compliance. 1/20/14 TS	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 162	Continued From page 3 Medicaid costs. Findings include: On 12/19/13 at 11:16 a.m., FM-1 was interviewed and stated that a list of services and items that he/she would be charged for was not provided with the admission process. On 12/19/13, at 12:25 p.m., social worker (SW)-B was interviewed, and verified the lack of evidence to indicate the information was provided to FM-1. The facility was unable to provide a policy and procedure regarding services or items not covered under Medicaid.	F 162	F 170 1. Corrective Action: Residents will receive their personal mail on Saturdays. 2. Corrective Action as it applies to other residents: Residents will receive personal mail delivery on Saturdays. 3. Reoccurrence will be prevented by: Activity staff and Social Services staff have been orientated to the "Mail Policy" and will ensure appropriate delivery to the nursing units every Saturday.	
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure that residents received their personal mail on Saturdays. This deficient practice had the potential to effect all 126 residents in the facility.	F 170	4. The Correction will be monitored by: Activities and Social Services 5. Date of Completion: 1/28/14 Addendum to #4. Weekend nursing staff to be assigned to check that Saturday mail delivered by 5:00pm with results reported to activities an social services. Results will be reportated to Quality Assurance committee to assess for ongoing compliance - 1/28/14 JS	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 170	Continued From page 4 Findings include: During an interview on 12/17/13, at 12:30 p.m. the resident council president (R49) asked if resident mail was delivered timely. R49 stated, "Looking at the date (on the envelope) it was mailed, it may be a week before I get it." R49 stated the mail should be delivered Monday-Saturday by 5 p.m.. The activity director (AD) was interviewed on 12/17/13, at 1:00 p.m. and stated the front desk staff delivered the mail. The business office manager (BO)-A, interviewed on 12/17/13, at 1:39 p.m., stated the mail was delivered to the facility Monday through Friday. The front desk staff sorted the mail by units and R4 delivered the mail to each unit. Nursing staff was responsible to deliver the mail to individual residents. BO-A further stated that even if mail was delivered on Saturdays there was no front desk staff to accept it. On 12/18/13 at approximately 1:00 p.m. R4 verified mail was not delivered to the facility on Saturdays because the, "Office is closed." The Resident Mail Delivery policy, last updated 12/17/13, indicated that when the mail is delivered on Saturdays, activity staff separate the	F 170	F170 Addendum to #3. Mail delivery will be added to resident council agenda to discuss monthly. TS 1/28/14 F 282 1. Corrective Action: The facility will provide care as directed by the plan of care specific to *ADL's, incontinence, repositioning,* and *Isolation precautions.* a.) R 33; fingernails have been cleaned and trimmed. b.) R 125 has expired. c.) R 23 and R 39 care plan and group sheets will be reviewed and revised as needed for appropriate repositioning and incontinence care. d.) R 108 will have the care plan and group sheets reviewed and revised as needed for appropriate repositioning. e.) R 34 care plan will be reviewed for appropriate Isolation Procedures/Precautions. R 34's chart and medical record was reviewed by DON, Nurse Practioner, and Physician. It was	

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F 170	Continued From page 5 personal mail from the business mail and personal mail would be delivered to the appropriate nursing units.	F 170	determined that no medical necessity was found for continued isolation. Isolation has been discontinued. The COTA has been re-educated on contact and droplet isolation precautions. 2. Corrective Action as it applies to other residents: a. The facility will develop a policy for diabetic nail care. 100% audit of all residents to ensure nail care is completed per plan of care. b. 100% audit of resident care plans and group sheets whom require repositioning and/or incontinence care to ensure that appropriate interventions are in place. c. There are currently no residents on Isolation Precautions.	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 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 1 of 3 residents (R33) reviewed for activities of daily living (ADLs); 2 of 3 residents (R23, R39) reviewed for incontinence; 4 of 4 residents (R23, R39, R108, R125) reviewed for pressure ulcers and 1 of 1 residents (R34) in isolation precautions. Findings include: R33 was observed, on 12/16/13, at 4:47 p.m. to have long, untrimmed fingernails with debris under the nails. R33's diagnoses included diabetes, glaucoma and shoulder pain. The admission Minimum Data Set (MDS) dated 9/4/13, indicated R44 required extensive assistance of one staff for personal hygiene (including nail care). R33's nail care was provided by licensed nursing staff due to the	F 282		

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F 282	Continued From page 6 diagnosis of diabetes.. On 12/18/13, at 2:39 p.m., registered nurse (RN)-C was interviewed and stated licensed nurses are to complete nail care on diabetic residents. On 12/19/13, at 2:28 p.m. the director of nursing (DON) verified diabetic nail care is to be done by licensed staff. The facility was unable to provide a policy and procedure on diabetic nail care. R125 was not repositioned as directed in the care plan. R125's diagnoses included dementia, chronic airway obstruction, generalized weakness, and malnutrition of moderate degree. The significant change Minimum Data Set (MDS) dated 11/26/13, indicated R125 had moderately impaired cognitive skills and required extensive assistance with bed mobility and transfers, currently had a Stage I pressure ulcer and was on a turning and repositioning schedule. R125's care plan updated 11/27/13, indicated a stage III pressure ulcer to the left hip, and directed staff to redistribute pressure 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. On 12/18/13, from 7:25 a.m. through 10:05 a.m.	F 282	3. Reoccurrence will be prevented by: a. Nursing staff in serviced to revised nail care policy. b. All residents' nails to be checked that they are clean and trimmed weekly x 1 month then monthly x 2 per the plan of care. Results will be reported to the Quality Assurance Committee to assess for ongoing compliance. c. Nursing staff inserviced on repositioning and incontinence care. d. Daily audits x 1 week and then 2 x week x 2 months to assure repositioning and/or incontinence care completed per care plan. Results will be reported to the Quality Assurance Committee to assess for ongoing	

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F 282	Continued From page 7 R125 was continually observed in the wheelchair. R125 was dressed for the day, and propelled his wheelchair from his room, into the dining room where he ate breakfast, and back to the unit. At no time during the observation did staff approach R125 to reposition, and R125 did not reposition himself. The director of nursing (DON) was interviewed on 12/19/13 at approximately 3:00 p.m. The DON stated she would expect staff to follow the care plan for R125's repositioning schedule. The facility policy and procedure on skin assessment and care revised 5/11, directs care plan interventions are determined with consideration of resident choice, interventions including pressure redistribution, and providing an individualized repositioning plan. R23 was not provided repositioning as directed by the plan of care. R23's plan of care dated as being reviewed 11/13, indicated R23 required extensive assistance for repositioning every two hours when in bed. R23 was observed on 12/18/13, at 4:30 a.m. to be laying on her back in bed. At this time nursing assistant (NA-I) turned R23 on her left side with a pillow behind her back. R23 was continually observed and no one re-entered her room, until 7:50 a.m. after the next shift came on (3 hours, 20 minutes).	F 282	compliance or the need for further audits. e. All departments will be updated of any resident on isolation precautions to include reason for isolation and type of isolation needed. 4. <u>The Correction will be monitored by:</u> DON, Unit Manager, and designees with oversight by Nursing Home Administrator. 5. <u>Date of Completion: 1/28/14</u>	

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F 282	Continued From page 8 Interview on 12/18/13, at 12 noon with registered nurse (RN-F) stated that R23 was to be repositioned and toileted every two hours. R23 was not provided incontinence care and toileting assistance on 12/18/13, as the plan of care indicated was needed. R23's plan of care dated as reviewed 11/13, indicated R23 was to be assisted to the toilet every two hours with two staff and a mechanical sit/stand lift. R23 was observed on 12/18/13, at 4:30 a.m. to be laying on her back in bed. At this time nursing assistant (NA-I) completed repositioning and changing R23's wet incontinent brief. R23 was not offered to use the bedpan at that time. R23 had been placed on her left side with a pillow behind her back. R23 was continually watched and no one reentered her room, until 7:50 a.m. (3 hours, 20 minutes). Interview on 12/18/13, at 12 noon with RN-F stated that R23 was to be toileted every two hours. On 12/18/13, at 12:20 p.m. interview with the director of nursing (DON) indicated that staff needed to follow the plan of care. R39 was at not provided every two hour repositioning as the plan of care directed.	F 282		

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F 282	Continued From page 9	F 282		

R39's plan of care dated as reviewed 11/6/13, indicated R39 at risk for pressure ulcer due to dementia, immobility, incontinence and needed assistance from staff to reposition at least every two hours and more as needed.

R39 was observed on 12/18/13, at 4:25 a.m. to be laying on her right side in bed. At that time NA-D completed repositioning and changing R39's incontinent brief. R39 had been placed on her left side with a pillow behind her back.

On 12/18/13, at 8:00 a.m. R39's was repositioned and her wet incontinent brief was checked and changed by NA-D. R39 was continually watched and remained on her left side facing the wall. No one re-entered the room, until 7:50 a.m. (3 hours and 35 minutes).

Interview with NA-D on 12/18/13, at approximately 7:50 a.m. she stated R39 was to be repositioned every two hours.

RN-F was interviewed on 12/18/13, at 12 noon and stated that R39 was to be repositioned and toileted every two hours.

The facility failed to provide R39 with incontinence care every two hours as the plan of care indicated was needed.

R39's plan of care (POC) dated as reviewed 11/13, indicated R39 was dependent with every

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F 282	Continued From page 10 two hour incontinence care. R39 was observed on 12/18/13, at 4:25 a.m. to be laying on her right side in bed. At that time NA-D completed incontinence care. R39 was continually observed from 4:25 a.m. until 7:50 a.m.. At 8:00 a.m. R39 was provided incontinence care by NA-D (3 hours and 35 minutes). Interview with NA-D on 12/18/13, at approximately 7:50 a.m. indicated R39 was to be checked and changed every two hours. Interview on 12/18/13, at 12 noon with registered nurse (RN-F) she stated that R39 was to be repositioned and toileted every two hours. R108 was not repositioned appropriately or in a timely manner according to the care plan. R108's diagnoses included hypertension, dementia, renal insufficiency, coronary artery disease, diabetes type 2, malignant neoplasm of the colon, and depression. A car plan revised 11/19/13, directed R108 required repositioning every 2 hours and prn [as needed] in bed and broda chair. On 12/18/13, R108 was under continuous observation from 5:04 a.m. until 7:42 a.m. At approximately 5:10 a.m. R108 was observed to be dressed and sitting up in the broda chair. NA-I pushed R108 into the dining room area on the unit where she remained until until 5:55 a.m. NA-E was observed to push R108 in the broda chair from the dining room into R108's room.	F 282		

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F 282	Continued From page 11 NA-E covered R108 with a blanket, turned off the room light, and asked R108 wanted any tunes on, and exited R108's room. At 7:30 a.m. R108 was observed to be up and asleep in broda chair in the room. At 7:42 a.m. NA-E and NA-D entered R108's room with the hoyer lift. NA-E was lifted from the broda chair with the lift sling for approximately 30 seconds and lowered back into the chair. NA-E removed the lift sling from the hoyer lift and tucked the ends around R108's shoulders and hips. NA-D opened R108's room door and exited the room with the hoyer lift. On 12/18/13, at 7:53 a.m. NA-E stated R108 is suppose to be repositioned every 2 hours and since R108 was last repositioned around 5:00 a.m. R108 should have been repositioned sooner than 7:30 a.m. On 12/19/13, at 10:00 a.m. RN-F stated R108's care plan for every 2 hours repositioning was the correct repositioning schedule. RN-F confirmed R108 was not repositioned in a timely manner, according to the care plan. RN-F verified repositioning should be more than lifting R108 up for a few seconds before lowering into the chair. A certified occupational therapy assistant (COTA)-A failed to wear appropriate personal protective equipment (PPE) and perform hand hygiene as directed in the plan of care when working with R34 who had an active Methicllin-resistant Staphylococcus aureus (MRSA) infection. R34's diagnoses include MRSA pneumonia and tracheostomy. R34's care plan dated 11/22/13 directed staff to	F 282		

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F 282	Continued From page 12 wear gowns, masks and gloves prior to entering the residents room. On 12/17/13 at 10:05 a.m. a sign was noted outside R34's room indicating contact and droplet 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 hands prior to leaving the room. COTA-A was interviewed at that time and indicated R34 had MRSA in his nares and she did not glove and gown because she was not providing direct care to the resident. COTA-A verified the hand sanitizer in the room was empty and that she didn't wash her hands prior to leaving R34's room. On 12/18/13 at 1:58 p.m. the director of nursing (DON) verified that COTA-A should have worn a gown and gloves while in R34's room and should have washed her hands before leaving the room.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		

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F 309	Continued From page 13 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate home health aid (HHA) hospice services with facility staff for 1 of 1 residents (R13) reviewed for hospice services. Findings include: R13's diagnoses included vascular dementia, history of a stroke (CVA), seizure disorder, anxiety, and depression. The quarterly Minimum Data Set (MDS) dated 10/16/13, indicated R13 had memory problems (short and long term) with severe cognitive impairment; required extensive to total assistance of staff with all activities of daily living (ADL's); was frequently incontinent of bladder; was always incontinent of bowel; and received hospice services. The hospice Recertification Statement for 60-day Period dated 11/5/13, indicated R13's diagnosis for hospice services was vascular dementia. The facility care plan reviewed 10/2013, indicated hospice involvement with nutrition, mood, skin care, falls and hospice services. The care plan did not indicate coordination or specific services provided by hospice as opposed to facility staff.	F 309	F 309 1. Corrective Action: R 13 has expired 2. Corrective Action as it applies to other residents: a. Any resident receiving Hospice services will have care plan reviewed and revised to reflect coordination of care between the facility and Hospice. b. Hospice will provide the facility with a schedule of planned HHA visits and services to be provided. 3. Reoccurrence will be prevented by: a. All nursing staff inserviced on coordination of care between the facility and Hospice. b. Any newly admitted residents to hospice will have a comprehensive care plan coordinating care	

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F 309	Continued From page 14 The hospice care plan dated as reviewed 11/21/13, indicated R13 was admitted to hospice services on 7/24/12. The care plan directed the HHA to visit one to two times a week to provide bath/bed bath/shower, mouth care, hair care, skin care, nail care, peri care, toileting/changing as needed, dressing, change bed linens, foot soaks, positioning, transferring, socialize, tidy room/bath, and assist with feeding if present for meals. The HHA Visit History documentation dated from 11/14/13, to 11/21/13, indicated the following tasks were completed by the HHA: 11/15/13 - Bath/shower/bed bath, hair care, skin care, peri care, toilet/check and change, dressing, changing bed linens, positioning, transferring, socializing, and tidy room/bath. 11/18/13 - Bath/shower/bed bath, hair care, skin care, peri care, dressing, positioning, transferring, socializing, and tidy room/bath. The record lacked the time of the HHA visits, the identity of the HHA, and evidence of communication with facility staff. In addition, there was no documentation of additional HHA visits. R13 was intermittently observed on the mornings and afternoons of 12/18/13, and 12/19/13. No HHA visits were noted during the observations. On 12/18/13, at 1:15 p.m. nursing assistant (NA)-B stated she had cared for R13 on 12/18/13, and on approximately five other occasions. NA-B stated she was unaware R13 received hospice services and did not know about any HHA visits.	F 309	between facility and Hospice. 4. The Correction will be monitored by: DON, Unit Managers, and designees with oversight by Nursing Home Administrator. 5. Date of Completion: 1/28/14	

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F 309	Continued From page 15 On 12/18/13, at 2:30 p.m. the registered nurse manager (RN)-F stated she was unaware of the frequency, days, or times of the hospice registered nurse (RN) or HHA visits for R13. RN-F stated she didn't believe there was any type of schedule. On 12/19/13, at 1:09 p.m. the trained medication aide (TMA)-A stated she was unsure exactly what day/time the hospice aide visited, but thought it was twice a week. TMA-A stated she thought the HHA just sat and talked with R13. On 12/19/13, at 2:25 p.m. NA-O and NA-D stated they had routinely cared for R13. NA-O stated she had seen the HHA and thought she came on Mondays. NA-D was unsure when the HHA visited. Both NA's stated they thought the HHA sat with R13, talked, and lotioned her hands, but were unsure what cares the HHA actually provided for R13. NA-O added, the HHA used to complete some cares, "But they don't do that anymore." On 12/19/13, at 4:22 a.m. the director of nursing (DON) was questioned regarding coordination of care between the facility and hospice agency. The DON verified there should be a way for staff to know when the hospice aides are coming, and what they do when they're in the facility. On 12/19/13, at 4:49 p.m. the DON confirmed R13's medical record lacked evidence of when the hospice aide visits or what cares were completed. The DON stated she called the hospice nurse who informed her that the HHA documentation	F 309		

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F 309	Continued From page 16 was faxed to the facility to be placed into R13's medical record. The DON verified the lack of coordination between the facility and the hospice.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided for 1 of 3 residents (R33) reviewed for activities of daily living (ADLs). Findings include: R33 had long fingernails with dark colored debris under the nails. R33's diagnoses included diabetes and glaucoma. The admission Minimum Data Set (MDS) dated 9/4/13, indicated R33 required extensive assistance of one staff for personal hygiene (including nail care). The care plan dated 9/11/13 indicated R33 required assistance with activities of daily living (ADLs), and directed licensed staff to cut nails due to R33's diagnosis of diabetes.	F 312	F 312 1. Corrective Action: a. R 33 nails have been cleaned and trimmed by licensed staff 2. Corrective Action as it applies to other residents: a. Reviewed and revised nail care policy to include diabetic nail care. b. 100% audit of all residents to ensure nail care is completed per plan of care. 3. Reoccurrence will be prevented by: a. All nursing staff inserviced on the revised nail care policy. b. All residents' nails to be checked that they are clean and trimmed weekly x 1 month then monthly x2. Results will be reported to the Quality Assurance Committee to assess for ongoing	

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F 312	Continued From page 17 On 12/16/13, at 4:47 p.m. R33 was observed with long, untrimmed fingernails that had debris under the nails. R33 was interviewed on 12/19/13, at 1:27 p.m. and stated the nurses provide nail care. On 12/18/13, at 2:39 p.m., registered nurse (RN)-C was interviewed and stated licensed nurses are to complete nail care for diabetic residents. On 12/19/13, at 2:28 p.m. the director of nursing (DON) verified diabetic nail care is to be provided only by licensed staff. The facility was unable to provide a policy and procedure on diabetic nail care.	F 312	compliance or the need for further audits. 4. <u>The Correction will be monitored by:</u> DON, Unit Managers, and designees with oversight by Nursing Home Administrator. 5. <u>Date of Completion: 1/28/14</u>	
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that 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 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning to prevent the development of pressure ulcers or promote healing of pressure ulcers for 4 of 4 residents.(R125, R23, R39, R108).	F 314		

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F 314	Continued From page 18 Findings include: R125 was not repositioned as directed in the care plan. Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Stage III: Full thickness skin loss Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Bone/tendon is not visible or directly palpable. Stage IV: Full thickness tissue loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. Exposed bone/muscle is visible or directly palpable.	F 314	F 314 1. Corrective Action: a. R 125 has expired. b. R 23, R 39, and R 108 care plans and group sheets reviewed and revised as needed for appropriate repositioning to prevent pressure sores. 2. Corrective Action as it applies to other residents: a. 100% audit of all resident care plans and group sheets who have pressure sores or who are at risk based on the comprehensive assessment to ensure that an appropriate repositioning plan of care is in place. 3. Reoccurrence will be prevented by: a. All nursing staff in serviced on pressure sore	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 19 Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined. R125's diagnoses included dementia, chronic airway obstruction, generalized weakness, and moderate malnutrition. The significant change Minimum Data Set (MDS) dated 11/26/13, indicated R125 had moderately impaired cognitive skills for daily decision making, had difficulty focusing attention and had disorganized thinking. The MDS further indicated R125 required extensive assistance with bed mobility and transfers, currently had a Stage I pressure ulcer (location not identified), was on a turning and repositioning schedule, and was at risk for the development of pressure ulcers. The Care Area Assessment (CAA) dated 12/2/13, indicated R125 was at risk for the development of pressure ulcers due to incontinence of bowel and bladder, declined mobility and need of assist with transfers, and currently had scabbed areas to the left knee and left elbow. The CAA also indicated R125 had a current Stage I pressure ulcer (location not identified), required a special mattress or seat cushion to reduce or relieve pressure, and required a regular schedule of turning.	F 314	prevention/treatment with repositioning. b. Daily audits x 1 week and then 2 x weekly x 2 months to assure repositioning completed per care plan. Results will be reported to the Quality Assurance Committee to assess for ongoing compliance or the need for further audits. 4. The Correction will be monitored by: DON, Unit Managers, and Designees with oversight by Nursing Home Administrator 5. Date of Completion: 1/28/14 Addendum to #3. c. Direct care observation to be completed weekly & results reported to the Quality assurance Committee to assess for ongoing compliance 1/28/14 TS	

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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. 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 on the left heel. RN-C did not identify an ulcer of the left hip. R125 was continuously observed in the	F 314		

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F 314	Continued From page 21 wheelchair on 12/18/13, from 7:25 a.m. through 10:05 a.m.. R125 was dressed for the day, and propelled his wheelchair from his room, into the dining room where he ate breakfast, and back to the unit. At no time during the observation did staff approach R125 to offer repositioning and R125 did not reposition himself. At 9:45 a.m. the surveyor informed RN-D regarding R125's lack of repositioning. At 10:05 a.m. nursing assistant (NA)-A transferred R125 into bed. R125's skin was observed with RN-C at 10:08 a.m. RN-C stated R125 had had a recurring pressure ulcer on the left hip that opens and closes. RN-C further stated the left hip ulcer had not been open, "But it is now." RN-C measured the pressure area at 0.8 cm x 0.8 cm and later stated it was a Stage II. RN-C cleansed the pressure ulcer, applied a dermagauze dressing and covered it with gauze. On 12/19/13, at 2:59 a.m. NA-B was interviewed, and stated R125 was approached to reposition, but usually refuses. On 12/18/13, at 2:22 p.m. RN-C was interviewed and verified the nursing assistant assignment sheet lacked repositioning directions. RN-C further stated she would expect staff to be repositioning R125 every one and a half hours. On 12/19/13, at 11:49 a.m. RN-C stated pressure ulcers are documented in the skin book, and it should have been documented when the pressure ulcer to the left hip healed. The director of nursing (DON) was interviewed on 12/19/13 at approximately 3:00 p.m. The DON	F 314		

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F 314	Continued From page 22 stated she would expect staff to follow the care plan for R125's repositioning schedule. The facility policy and procedure on skin assessment and care revised 5/11, directs care plan interventions are determined with consideration of resident choice, interventions including pressure redistribution, and providing an individualized repositioning plan. R23 was not provided every two hour repositioning assistance as the assessment indicated was needed. The quarterly MDS dated 11/20/13, indicated R23 had severe cognitive impairment, was non-ambulatory, required extensive assistance from two staff to transfer, had range of motion limitations in the upper and lower extremities and was always incontinent of urine. The quarterly MDS also indicated R23 was at risk for pressure ulcer, had a history of buttocks pressure ulcers and had scar tissue that increased the risk of pressure ulcers. The Skin Assessment dated 8/21/13, indicated R23 was at risk for alteration in skin due to diagnosis of dementia, Parkinson, neuropathy, antidepressant use, antipsychotic use, use of a positioning devices (body pillow) and the frequency of bladder incontinence. The assessment indicated R23 was chair bound and had potential of friction shearing due to slouching in a chair. R23 was assessed to require every two hour toileting/repositioning with extensive assistance of two staff.	F 314		

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	245227	A. BUILDING _____ B. WING _____	12/19/2013

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F 314	Continued From page 23 The Skin Ulcer Data Collection and Assessment dated 12/3/13, indicated R23 had a stage one pressure ulcer on the buttocks measuring 8 cm by 6 cm involving partial thickness of skin. The plan of care (POC) dated as being reviewed 11/13, indicated R23 required extensive assistance for repositioning every two hours when in bed. The undated Nursing Assignment worksheet directed every two hour repositioning. On 12/18/13, at 4:30 a.m., R23 was laying on her back in bed and NA-I provided incontinence care and repositioning. R23 was observed to have two red areas above the coccyx area. The first area was approximately two inches by three inches with peeling skin. The second area was located in the buttocks crease, approximately two inches long by 1/8 inch wide. R23 was positioned on the left side with a pillow behind the back and remained in that position until 7:50 a.m.. At 8:08 a.m., R23 was provided incontinence care. The left hip and lateral leg were observed to be red in an area four inches by seven inches long. NA-L and NA-J used a mechanical standing lift to assist R23 onto the toilet. After 20 minutes the hip redness resolved; however, the buttocks area remained red as it had been when observed at 4:30 a.m.. NA-L, interviewed on 12/18/13, at approximately 8:30 a.m., stated R23 was to be repositioned every two hours. When asked what time R23 was last repositioned before getting up at 8:08 a.m.,	F 314		

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F 314	Continued From page 24 NA-L did not know, but the night shift would have last provided repositioning. During interview on 12/18/13, at 12 noon, RN-F stated that R23 was to be positioned and toileted every two hours. When asked how were nursing assistants were suppose to know when residents were last toileted and repositioned, RN-F stated the information was on the care sheets; however, R23's care sheet could not be located. R39 was not provided repositioning every two hours as the assessment indicated was needed. R39's annual MDS dated 10/23/13, indicated R39 had moderate cognitive impairment, was always incontinent of bowel and bladder, required extensive assistance or two or more staff with bed mobility, transfers and toileting, was at risk for pressure ulcers, and had a repositioning program. The Skin Assessment dated 7/31/13, indicated R39's was at risk for alteration in skin due to incontinence, immobility, preference to remain in bed all the time and the potential for friction skin shearing. The plan of care dated as reviewed 11/13, indicated R39 required assistance for turning and repositioning at least every 2 hours and more often as needed or as requested. It noted R39	F 314		

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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. R39 was observed on 12/18/13, at 4:25 a.m. to 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. R108's diagnoses included dementia, renal	F 314		

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F 314	Continued From page 26 insufficiency, coronary artery disease, diabetes type 2 and malignant neoplasm of the colon. The annual MDS dated 11/21/13, indicated R108 had short and long-term memory problems, had severely impaired cognitive skills for daily decision making, and displayed inattention and disorganized thinking behaviors. The MDS further indicated R108 had occasional delusional behaviors with verbal and physical behavior directed towards others and occasionally rejected provision of cares. The MDS also indicated R108 required extensive assistance with bed mobility and was totally dependent with transfers, toileting, personal hygiene, and bathing activities. A Skin Assessment dated 11/13/13, indicated R108 had a healed pressure ulcer on a heel with no skin breakdown at the time of assessment. The assessment further indicated R108 was to be repositioned, checked and changed every one and a half hours, had a cushion in the broda chair, and was at high risk for skin breakdown. A care plan revised 11/19/13, directed R108 required repositioning every 2 hours and prn [as needed] in bed and broda chair. On 12/18/13, R108 was under continuous observation from 5:04 a.m. until 7:42 a.m. At 5:04 a.m. R108 was yelling out was observed to have the legs and feet hanging out over the edge of the bed. NA-I and NA-J entered R108's room with a hoyer lift and closed the door. At approximately 5:10 a.m. R108 was observed to	F 314		

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F 314	Continued From page 27 be dressed and sitting up in the broda chair. NA-I pushed R108 into the dining room area on the unit. R108 remained in the dining room until 5:55 a.m. NA-E pushed R108 in the broda chair from the dining room into R108's room. NA-E covered R108 with a blanket, turned off the room light, and asked R108 wanted any tunes on, and then exited the room. At 7:30 a.m. R108 remained asleep in broda chair in the room. At 7:42 a.m. NA-E and NA-D entered R108's room with the hoyer lift, secured the lift sling to the hoyer lift, unbuckled R108's seat belt, and raised R108 off the seat of the broda chair for approximately 30 seconds. NA-E briefly examined R108's incontinent brief for wetness before R108 was lowered back into the chair. NA-E disconnected the lift sling from the hoyer lift and tucked the ends around R108's shoulders and hips. At 7:45 a.m. NA-E removed the gloves and sanitized her hands, asking if R108 would like a face wash. NA-E prepared a warm, wet wash cloth and wiped R108's face and then dried R108's face with a hand towel. NA-E brushed R108's hair and then re-buckled R108's seat buckle in the broda chair. NA-E sanitized her hands and pushed R108 in the broda chair out into the hallway. On 12/18/13, at 7:53 a.m. NA-E stated R108 was suppose to be repositioned every 2 hours and since R108 was last repositioned around 5:00 a.m. R108 should have been repositioned sooner than 7:30 a.m. On 12/19/13, at 10:00 a.m. RN-F stated R108's care plan for every 2 hours repositioning was the correct repositioning schedule. RN-F confirmed R108 was not repositioned in a timely manner,	F 314		

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F 314	Continued From page 28 according to the care plan, and that repositioning should be more than lifting R108 up for a few seconds before lowering into the chair. A Skin Assessment and Care policy reviewed and revised 5/2011, directed each resident would receive the necessary care and services to prevent the development of pressure ulcers or other skin problems and would include an individualized repositioning schedule.	F 314	F 315 1. Corrective Action: R23 and R39 care plans and group sheets reviewed and revised as needed for appropriate incontinence care. 2. Corrective Action as it applies to other residents: 100% audit of all resident care plans and group sheets whom require incontinence care to ensure that appropriate interventions are in place. 3. Reoccurrence will be prevented by: a. All nursing staff will be in serviced on incontinence care. b. Daily audits x 1 week and then 2 x weekly x 2 months to assure repositioning and/or incontinence care completed per care plan. Results will be reported to the Quality Assurance Committee to assess for ongoing compliance or the	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide timely assistance with incontinence cares directed by the plan of care for 2 of 4 residents (R23, R39) reviewed for incontinence. Findings included:	F 315		

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F 315	Continued From page 29 The facility failed to provide R23 with incontinence care 12/18/13, as the assessment indicated was needed. The Incontinence Care Area Assessment (CAA) dated 8/21/13, indicated R23 had bladder incontinence and required staff assistance for all activities of daily living. The assessment noted contributing factors to R23's incontinence included delirium, psychological problems, pain, restricted mobility and urinary urgency. The quarterly Minimum Data Set (MDS) dated 11/20/13, indicated R23 was severely cognitively impaired, required extensive assistance or two staff for transfers, had limitations in range of motion to upper and lower extremities and was always incontinent of urine The quarterly bowel and bladder status assessment dated 11/20/13, indicated R23 had functional bladder and bowel incontinence. The assessment indicated staff were to provide all transfers on/off toilet with assist of two and a pivot disc or mechanical lift, assist with the use of the bedpan, incontinence care, adjusting clothing, and changing of incontinence brief. It concluded that R23 needed to be toileted and repositioned every two hours with extensive assistance of two staff. R23's plan of care dated as reviewed 11/13, indicated R23 was to be assisted to toilet with two staff and a mechanical sit/stand lift. R23 was to be toileted every two hours and as needed	F 315	need for further audits. 4. The Correction will be monitored by: DON, Unit Managers, and Designees with oversight by Nursing Home Administrator 5. Date of Completion: 1/28/14 Addendum to # 3. c. Direct care observation to be completed weekly with results reported to the Quality assurance committee to assess for ongoing compliance. 1/28/14 JS	

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F 315	Continued From page 29 The facility failed to provide R23 with incontinence care 12/18/13, as the assessment indicated was needed. The incontinence Care Area Assessment (CAA) dated 8/21/13, indicated R23 had bladder incontinence and required staff assistance for all activities of daily living. The assessment noted contributing factors to R23's incontinence included delirium, psychological problems, pain, restricted mobility and urinary urgency. The quarterly Minimum Data Set (MDS) dated 11/20/13, indicated R23 was severely cognitively impaired, required extensive assistance or two staff for transfers, had limitations in range of motion to upper and lower extremities and was always incontinent of urine The quarterly bowel and bladder status assessment dated 11/20/13, indicated R23 had functional bladder and bowel incontinence. The assessment indicated staff were to provide all transfers on/off toilet with assist of two and a pivot disc or mechanical lift, assist with the use of the bedpan, incontinence care, adjusting clothing, and changing of incontinence brief. It concluded that R23 needed to be toileted and repositioned every two hours with extensive assistance of two staff. R23's plan of care dated as reviewed 11/13, indicated R23 was to be assisted to toilet with two staff and a mechanical sit/stand lift. R23 was to be toileted every two hours and as needed	F 315	need for further audits. 4. The Correction will be monitored by: DON, Unit Managers, and Designees with oversight by Nursing Home Administrator 5. Date of Completion: 1/28/14	

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F 315	Continued From page 30 during waking hours. Resident was to be assisted with the use of the bed pan when in bed. Staff would provide incontinence care. R23 was observed on 12/18/13, at 4:30 a.m. to be laying on her back in bed. At that time nursing assistant (NA-I) completed repositioning and changing R23's incontinent brief. R23 had been placed on her left side with a pillow behind her back, she was not offered the bed pan at that time. R23 was continually observed and no staff entered her room from 4:30 a.m. until 7:50 a.m.. On 12/18/13, at 8:08 a.m. R23's wet incontinent brief was checked and changed by NA-L. R23 was assisted to the toilet by NA-L and NA-J with a mechanical standing lift. During interview on 12/18/13, at approximately 8:30 a.m., NA-L stated R23 was to be repositioned, checked and changed every two hours. NA-L did not know when R23 was checked and/or changed before getting up at 8:08 a.m.. Registered nurse (RN)-F, interviewed on 12/18/13, at 12 noon, stated that R23 was to be repositioned and toileted every two hours. When asked how nursing assistants were suppose to know when residents were last toileted and repositioned when a new work shift came on, she said that they could look at the care sheets. RN-F looked where the completed resident care sheets were suppose to be kept, but there was no care sheet for R23.	F 315		

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F 315	Continued From page 31 R39 was not provided incontinence care every two hours as the assessment indicated was needed. The Bowel and Bladder Assessment dated 7/31/13, indicated R39 was incontinent of bowel and bladder and dependent on staff for all of her toileting needs. R39 wore an incontinence brief for dignity, was asked every two hours if they needed to use the toilet but usually refuses. Staff were to provide perineal care, brief changes, clothing adjustment prior to and after toileting. The CAA dated 8/21/13 indicated R39 had bladder incontinence and required staff assistance with all activities of daily living. The assessment identified risk factors of incontinence including delirium, psychological problems, pain, restricted mobility, and urinary urgency. R39's annual MDS dated 10/23/13, identified moderate cognitive impairment, dependence upon staff for bed mobility, transfers, and incontinence care. R39's plan of care dated as reviewed 11/13, indicated R39 was dependent upon staff for toileting and required check/change incontinence care every two hours and as needed. The undated Nursing Assignment worksheet directed staff assistance to check/change and toilet every two hours and as needed. R39 was observed on 12/18/13, at 4:25 a.m. to	F 315		

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F 315	Continued From page 32 be laying on her right side in bed and NA-D provided incontinence care and repositioning. R39 was continually observed from 4:25 a.m. until 7:50 a.m.. At 8:00 a.m., NA-D provided incontinence care. During interview on 12/18/13, at approximately 7:50 a.m., NA-D stated R39 was to be checked and changed every two hours. NA-D did not know when R39 was previously provided incontinence care. RN-F, interviewed on 12/18/13, at 12 noon, stated that R39 was to be repositioned and toileted every two hours. When asked how were nursing assistants suppose to know when the residents had been last toileted and repositioned when a new work shift came on, RN-F stated that they could look at the care sheets; however, R39's care sheet was not located.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide	F 323	F 323 1. Corrective Action: R 120's fall of 12/12/13 was been reviewed on 12/20/13 by IDT care plan and group sheet audited to assure that fall prevention strategies implemented. 2. Corrective Action as it applies to other residents: 100% audit of all care plans and group sheets to assure all assessed fall prevention interventions are correctly in place. 3. Reoccurrence will be prevented by: a. All licensed nursing staff will be in serviced on Fall Prevention Policy b. Daily morning meeting will include Risk Management-IDT Incident/Accident review of all falls the prior 24 hours. Audit will be completed on assessment/care plan	

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F 323	Continued From page 33 comprehensive assessment following a fall for 1 of 3 residents (R120) reviewed for accidents. Findings include: R120 was admitted from a hospital due to increasing falls per the hospital discharge summary dated 8/27/13. R120 had an unwitnessed fall in his room on 12/12/13, and did not have a comprehensive follow up fall assessment. The admission Minimum Data Set (MDS) dated 9/6/13, indicated R120 had diagnosis that included Multiple Sclerosis, dementia, and post traumatic stress. The MDS indicated R120 could walk in his room with the physical assist of one staff. The fall risk assessment dated 9/10/13, indicated R120 was at risk for falls and had been receiving skilled therapy services. The discharge physical therapy (PT) note indicated R120 remained at high risk for falls. R120 forgot to set the wheelchair brakes, dragged the right foot when walking, had poor balance and required assistance with all activities of daily living. The plan of care dated as reviewed on 9/13, indicated R120 had moderate cognitive impairment and was at high risk for falls. The care plan directed the call light within reach, grab bars on the bed to assist with mobility and repositioning, assist of one for ambulation and toileting, walk to and from meals with voice	F 323	update and if further action required. 4. The Correction will be monitored by: DON, Unit Manager, and Designees with oversight by Nursing Home Administrator. 5. Date of Completion: 1/28/14 Addendum to #3. Results will be reported to the Quality Assurance Committee to assess for ongoing compliance or the need for ongoing audits. 1/28/14 PS MB	

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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 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. On 12/13/13, Registered Nurse (RN)-F added a note to the incident report indicating there would be a night light added. RN-F was interviewed on	F 323		

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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. 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 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325		

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F 325	Continued From page 36 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify, assess and address significant weight loss for 2 of 3 residents (R35, R22) reviewed for nutrition. This resulted in actual harm for R22. Findings include: R22's diagnoses list included anoxic brain damage and persistent vegetative state. R22's quarterly Minimum Data Set (MDS) dated 11/15/13, indicated R22 was totally dependent in all activities of daily living (ADL's) to include eating. The 11/15/13, MDS specified R22 had a feeding tube and had no weight loss; however the current weight value was not documented on the MDS. The Nutritional Status Assessment dated 2/13/13, indicated R22 was at nutritional risk due to reliance on others to administer tube feedings related to being in a vegetative state. The 2/13/13, assessment noted R22 weighed 149 lbs., was NPO (nothing by mouth), and received	F 325	F 325 1. Corrective Action: a. R 22 tube feeding increased from 30 ~~ERROR~~ 230cc cc/hr to 250 cc/hr and placed on weekly weights. 1/28/14 TS b. R 35 care plan will be reviewed and placed on weekly weights. 2. Corrective Action as it applies to other residents: 100% audit of all residents for significant weight gain or loss. 3. Reoccurrence will be prevented by: a. All residents on tube feeding and/or nutritional risk will be placed on weekly weights. b. Weekly weights to be obtained by restorative nurse aides c. Dietician, Unit Manager, and DON to review weekly weights at IDT meeting	

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F 325	Continued From page 37 Jevity 1.5 at 230 cc per hour four times per day via feeding tube. The 2/13/13, assessment indicated R22's estimated caloric need was 1564 to 1836 kcal with 54 grams of protein; however, the physician ordered Jevity 1.5 provided only 1470 kcal's per day and 76 grams of total protein. The weight history indicated R22 weighed 149 lbs on 6/2/13; 145 lbs on 9/30/13; 150 lbs on 10/5/13, and 134 lbs on 12/13/13. There was no documented weight between 10/5/13 and 12/13/13. On 12/19/13, at 2:45 p.m. the registered dietician/dietary director (RD/DD)-C stated R22 weighed 131 lbs on 12/18/13, indicating a 19 lb weight loss (12.9%) in 75 days. R22's electronic nutrition progress note dated 11/18/13, identified as a quarterly nutrition assessment, indicated R22 continued on tube feeding to meet 100% of nutritional needs via PEG (percutaneous endoscopic gastrostomy) tube due to anoxic brain damage and persistent vegetative state. The progress note verified the lack of a current weight value and indicated R22's weight had been stable in the past. A care plan revised 8/19/13, indicated R22 was at nutritional risk due to 100% of nutrition needs met via PEG tube due to anoxia brain damage, vegetative state, and NPO status. R22's care plan included a goal R22 would maintain weight of 140 lbs + or - 5 lbs with interventions to include observation of labs and weights as ordered. Physician's orders dated 11/26/13, directed R22	F 325	4. The Correction will be monitored by: Don, Dietician, and Unit Managers with oversight by Nursing Home Administrator 5. Date of Completion: 1/28/14 Addendum to #3. Results will be reported to the Quality Assurance Committee to assess for ongoing compliance or the need for ongoing audits. - 1/28/14 TS MB	

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F 325	Continued From page 38 was NPO and was to receive Jevity 1.5 Cal Liquid, 230 cc enterally four times a day for health maintenance. On 12/18/13 at 11:17 a.m. registered nurse (RN)-G was observed to administer R22 the Jevity 1.5 feeding per PEG tube. RN-G applied disposable gloves, checked tube placement, flushed the tubing with water and inserted the tubing connected to a bottle of the Jevity solution hanging on a metal pole near R22's bedside. RN-G pressed the "on" button located on R22's Kangaroo pump and noted the administration rate set at 70cc/hr instead of 230 cc/hr. RN-G checked the physician's order and confirmed the tube feeding administration rate was 230 cc per hour. RN-G reset the feeding pump to 230 cc/hr. RN-G, interviewed on 12/19/13, at 12:37 p.m., stated she talked with the licensed practical nurse (LPN) working with R22 on the previous shift regarding the Kangaroo pump being set at 70 cc/hr. The LPN verified the pump rate had reset to 70 cc per hour as a result of being unplugged and confirmed the rate should have been at 230 cc per hour. There was no indication of how long the feeding pump had been set at the lower rate or if R22 had actually been provided the correct amount of Jevity 1.5. On 12/18/13, at 12:00 p.m. (RD/DD)-C stated R22's weight of 134 lbs on 12/13/13, had not yet been assessed. On 12/19/13, at 8:40 a.m. RD/DD-C stated residents are weighed at least every month, and R22 should have been weighed in November for the quarterly review. A policy on tube feedings and weight loss issues	F 325		

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F 325	Continued From page 39 was requested from the facility on 12/19/13. The policy provided was dated 12/19/13, and indicated weights should be tracked on an on-going basis for the purpose of assessing weight changes and monthly weights would be reviewed by the registered dietician each month to calculate significant change over 1 (5%), 3 (7.5%) and a 6 (10%) months. R35 was not provided nutritional supplements related to an unplanned significant weight loss of 9.5% in 90 days. R35's diagnoses included diabetes, colitis, chronic airway obstruction, esophageal reflux, chronic pancreatitis and history of clostridium difficile. The quarterly MDS dated 11/21/13, indicated R35 had moderately impaired cognitive skills for daily decision making. The MDS further indicated R35 required extensive assistance of one staff for eating, had no swallowing disorders, no weight loss, and was on a mechanically altered therapeutic diet. R35's care plan reviewed 11/27/13, indicated R35 was at nutrition risk due to factors such as a therapeutic diet and leaves 25% or more of food uneaten at meals. R35's goal was to maintain adequate nutritional status by maintaining weight within 5% of 125 pounds, consuming 75% of all meals and accept >75% of supplements. Interventions for R35 included the following: is able to feed self once tray is set up, and	F 325		

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F 325	Continued From page 40 RD/DD-C to evaluate and make diet change recommendations as needed. The physician's orders signed 11/1/13 directed a consistent carbohydrate diet (diabetic diet) with 3 grams sodium, regular texture and regular consistency liquids. On 11/21/13, the progress notes indicated "WEIGHT WARNING." R35 had a 5.0% weight loss over 30 days, and a 7.5% weight loss over 90 days. On 11/22/13, RD/DD-C entered a progress note that indicated the following: R35 was on a mechanical soft texture diet, with intake averaging 25%. A nutritional supplement was stopped due to R35's dislike, and R35's weight was 105 pounds, trending down due to medical problems. The progress note further indicated the dietician would monitor R35's weight monthly and as needed with changes. R35's record lacked any further dietary progress notes. The weight record indicated R35 weighed 115 lbs on 9/12/13; 109 lbs on 10/5/13 and 105 lbs on 11/20/13. On 12/19/13, at 12:12 p.m. R35 was observed eating his lunch meal in his room. The meal consisted of spaghetti, two meatballs, green beans, a breadstick, a piece of cake and approximately 6 ounces of milk. R35 was able to feed himself, and took a few bites of cake and approximately 2 ounces of milk. At 12:26 p.m. R35 stated he was done and asked to lie down. On 12/19/13 at 1:42 p.m. RD/DD-C was	F 325		

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F 325	Continued From page 41 interviewed and stated R35 had been on a nutritional supplement, but he was not taking it so she discontinued it. RD/DD-C further stated R35's average meal intake was 25-50% of meals for the month of December, 25% of meals for the last half of November 50-100% of meals for middle of November, and 25-50% of meals in October. RD/DD-C stated she did not provided fortified foods for R35. RD/DD verified the weight warning received on 11/21/13, and stated significant weight loss is communicated to nursing staff weekly during the interdisciplinary team (IDT)meetings. RD/DD-C stated R35's weight loss was not addressed at IDT meetings for the last two months.	F 325		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to ensure 1 of 1 residents (R113) was free from a significant med error over 16 days. Findings include: R113's diagnoses included history of stroke with hemiplegia, cerebrovascular disease, history of deep vein thrombosis and long term use of anticoagulants (medications that reduce the ability of the blood to clot).	F 333	F 333 1. Corrective Action: R 113's medication error discovered 8/20/13 and omitted medication started. Physician was updated on 8/21/13 with no new orders. Resident suffered no adverse effects. 2. Corrective Action as it applies to other residents: All new medication orders and consultations will go through a triple-check process with final Order Transcription Audit completed by Unit Manager or designee. 3. Reoccurrence will be prevented by: a. Physician Orders procedure reviewed and revised to include triple –check procedure of all telephone orders, consults, and Physician on-site orders. b. All licensed staff, medical records, and	

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F 333	Continued From page 42 On 8/2/13, R113 was hospitalized, and returned to the facility on 8/3/13, with physician orders to discontinue warfarin (anticoagulant medication) and to start aspirin 81 milligrams daily. The facility signed off the orders as completed on 8/21/13; however, the ordered dose of aspirin was not initiated until 8/20/13, missing a total of 16 doses. The physician was notified on 8/21/13, and gave no new orders. No interviews were completed due to no staff currently working at the facility were working at the time of the medication error. The facility policy and procedure on adverse consequences and medication errors dated 4/13 directed a medication error includes an omission - a drug is ordered but not administered.	F 333	HUC's will be in serviced on new procedure. c. Ongoing Order Transcription audits of all new physician orders and results will be reported to the Quality Assurance Committee quarterly to assess for ongoing compliance and the need for further audits. 4. <u>The Correction will be monitored by:</u> DON, Unit Managers, and designees with oversight by Nursing Home Administrator 5. <u>Date of Completion: 1/28/14</u>	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		

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F 441	Continued From page 43 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to have an effective infection control program related to lack of tracking employee illness, training new employees on the facility infection control polices and procedure and surveillance to ensuring staff is following the facility infection control policies and procedures. This deficient practice had the potential to effect all 126 residents In addition staff failed to follow proper infection control practices for 1 of 1 residents (R34) in droplet isolation precautions.	F 441	F 441 1. Corrective Action: COTA-A will be re-educated on contact and droplet isolation precautions. R 34's chart and medical record was reviewed by DON, Nurse Practioner, and Physician. No medical necessity was found for continued isolation. Isolation discontinued. 2. Corrective Action as it applies to other residents: a. No other residents on isolation at present time b. Human resources to track employee illness using a line list. c. New employees will receive training on infection control and blood borne pathogens. 3. Reoccurrence will be prevented by: a. Procedures reviewed and revised on tracking	

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F 441	Continued From page 44 Findings include: A certified occupational therapy assistant (COTA)-A failed to wear appropriate personal protective equipment (PPE) and perform hand hygiene when working with R34 who had an active Methicllin-resistant Staphylococcus aureus (MRSA) infection. R34's diagnoses include MRSA pneumonia and tracheostomy (surgical procedure to create an opening through the neck into the trachea [windpipe]). A nursing note dated 11/7/13 indicated, d/t (due to) infection risk and safety to [R34] and all his caregivers, NP (nurse practitioner) wants [R34] to receive isolation techniques in place with supplies kept outside his room. R34's care plan dated 11/22/13 directed staff to wear gowns, masks and gloves prior to entering the residents room On 12/17/13 at 10:05 a.m. a sign was noted outside R34's room indicating contact and droplet 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	F 441	of employee infections. b. All facility staff will be in serviced on infection control procedures including types of isolation, hand washing, and employee illness. c. New employee policy and procedure reviewed and revised to include infection control and blood borne pathogens. d. All departments will be updated of any resident on isolation precautions to include reason for isolation and type of isolation needed. e. DON or infection control nurse to review employee line list at least weekly. f. Hand washing audits of staff with return demonstration.	

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F 441	Continued From page 45 hands prior to leaving the room. COTA-A was interviewed at that time and indicated R34 had MRSA in his nares and she did not glove and gown because she was not providing direct care to the resident. COTA-A verified the hand sanitizer in the room was empty and that she didn't wash her hands prior to leaving R34's room. At 10:15 a.m. a registered nurse (RN-B) was interviewed and stated R34 was in isolation due to a respiratory infection. RN-B further stated she didn't know what the organism was. On 12/18/13 at 1:58 p.m. the director of nursing (DON) verified that COTA-A should have worn a gown and gloves while in R34's room and should have washed her hands before leaving the room. DON further indicated that they (facility) must have a lack of communication that COTA-A and RN-B didn't know what type of, or where, R34's infection was. When questioned about the facility's procedures to monitor staff to ensure that they are employing appropriate infection control practices DON indicated that she was unaware of a facility system and had planned on conducting random audits of hand washing in the future. The facility Type and Duration of Precaution Required for Infections and Conditions policy dated 2007 directed staff to wear a mask & eye precautions within 3 feet of a patient and to wear gown and gloves as per standard precautions. .	F 441	g. Results of audits will be reported to the Quality Assurance Committee to assess for ongoing compliance and the need for further audits. 4. <u>The Correction will be monitored by:</u> DON, Infection Control Nurse, Unit Managers, and designees with oversight by Nursing Home Administrator. 5. <u>Date of Completion: 1/28/14</u> F441 Review employee line list @ least weekly> do that enough? What if a staff should not be back @ work?	

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F 441	Continued From page 46 The facility's infection control program lacked a system to track employee illness and to ensure new employees were trained for appropriate infection control procedures. The DON was interviewed on 12/18/13, at 2:00 p.m. regarding the facility infection control program. The DON stated there was no policy or procedure for tracking employee illness. DON stated. "I have been here a month I have not heard of any system of tracking employee illness-obviously they must not be tracking it because I should know." DON further stated the human resources department gets the information regarding employee illness, but she didn't know what they did with the information. The facility's policy regarding tracking of employee illness was requested but not provided. DON further indicated she was not sure what or how new employees are being trained in infection control or blood borne pathogens At 2:30 p.m. DON provided the facility new employee orientation evaluation checklist and stated, "I see there is no (blood borne pathogens) training on here."	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 47 by: Based on observation interview and document review the facility failed to ensure that resident rooms were maintained in a sanitary and homelike manner for 14 of 126 residents (R182, R125, R13, R1, R165, R18, R138, R40, R126, R102, R143, R81, R76, R55) related to broken veneer on doors and drawers, missing or peeling wallpaper, and unclean surfaces in bathrooms and floors. Findings include: The facility lacked a system to identify and repair environmental issues in resident rooms. On 12/18/13 at 2:00 p.m. during an environmental tour with the maintenance manager (MM)-A and two of the housekeeping staff (HK)-A and (HK)-B the following was noted; Rehab Unit R182's room had a built-in dresser with missing veneer, the bathroom door was marred and scratched. The grab bar in the bathroom was covered with foam. HK-A verified the grab bar had a uncleanable surface. R125's room had a built-in dresser with missing veneer, the bathroom door was marred and scratched. The heat register was marred and had an area approximately four by four inches of loose metal. MM-A verified the heat register needed repair. R13's room had a built-in dresser with missing veneer, the bathroom door was marred and scratched.	F 465	F 465 1. Corrective Action: The facility will maintain resident rooms to preserve a sanitary and homelike environment. The items identified during the survey will be assessed and renovated accordingly. 2. Corrective Action as it applies to other residents: The facility will complete an audit of all resident rooms for repairs and renovate as necessary. 3. Reoccurrence will be prevented by: The facility utilizes a TELS system for Preventative Maintenance and as a communication tool to identify potential maintenance problems. The housekeeping dept. will be in serviced to identify potential repairs and communicate that information to Maintenance Dept. during routine rounds.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 465	Continued From page 48 Morning Light Unit R1's bathroom had an area of torn and missing wallpaper above the sink approximately one foot long by six inches wide. The caulk around the base of the toilet was not intact and had black spots. MM-A verified the caulk needed to be replaced and that the area was not a cleanable surface. R165's room door had Velcro on the inside handle and on the wall behind the door. HK-A verified they were uncleanable surfaces. The bathroom door and missing veneer and black scuffs marks. R18's bathroom had missing caulk around the base of the toilet. R138's room had an area approximately four by four inches long of missing drywall above the bed. MM-A indicate that a cable box had been in that area. R40 had a mattress as a floor mat next to the bed. The mattress vinyl cover had a tear in it approximately 2 feet long resulting in exposed foam. MM-A stated, "That needs to be thrown away!" R126's room had black areas next to hinges on the bathroom door. HK-A was able to wipe the area with a rag and indicated it was grease from the hinges. The base board to the right of the bathroom door had an area approximately six inches long the was pulled away from the wall.	F 465	The Maintenance Dept. has divided the facility into 5 sections and will complete an environmental tour to document every resident room is observed on a weekly basis. 4. The Correction will be monitored by: Maintenance and Housekeeping during routine walking rounds. 5. Date of Completion: 1/28/14 Addendum to # 3. Results will be reported to the Quality Assurance Committee to assess for ongoing compliance and ongoing audits. 1/28/14 TS	

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F 465	Continued From page 49 The caulk around the base of the toilet was not intact. The plastic light fixture in the bathroom was cracked. MM-A verified the room need repairs. R102 and R143's room door had Velcro on the inside handle that was covered with duct tape. The duct tape was rolled up in a ball exposing parts of the adhesive side. The wall behind the door was dented and had missing drywall. The privacy curtain next to R143's bed had brown substance area approximately six inches by one inch. The bathroom door had missing veneer and black scuffs. HK-A verified the curtain needed to be washed and the room needed repairs. R81's room had brown water stains on the corner of the bathroom ceiling approximately eight inches by eight inches size. The bathroom floor was missing three tiles near the toilet. The bathroom light fixture had a crack in it approximately six inches long. MM-A indicated he didn't know what the brown area on the ceiling was but verified the tile and light fixtures need to be replaced Park Breeze unit R76's room had 2 gouges in the drywall behind the bed. R76's quarterly minimum data set (MDS) dated 9/6/13 identified R76 as having intact cognition,. When asked about the gouges R76 indicated he didn't cause the gouges, they were there when he moved into the facility three years ago. R55's room had two gouges in the drywall above her bed and the built in dresser had missing and	F 465		

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F 465	Continued From page 50 chipped veneer. MM-A verified during the tour that the facility did not have an ongoing preventive maintenance program specifically for residents room. MM-A indicated he would expect staff to tell him of area's that needed repair. On 12/18/13 at 3:30 p.m. .the administrator indicated the facility used a computer program called TELS that alerts maintenance of what areas within the facility to review every two weeks to yearly for preventive maintenance. Review of the areas listed on the TELS screen did not include resident rooms. The facility failed to ensure cleanable surfaces in the small refrigerator in the kitchen. During tour of the kitchen on 12/16/13, at 12:00 noon with the food service director the wire shelves of the small refrigerator had three rusted metal racks that were not cleanable. The metal shelves contained glasses of juices prepared for service. The shelves also contained approximately 20 salads in individuals bowls that were ready to be served. The Food Storage policy dated 2010 indicated that all refrigerator units are kept clean and in good working condition at all times. The food service director stated on 12/16/13, at 12:00 p.m. that she knew that a new cooler was needed and confirmed the rusted selves were not	F 465		

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F 465	Continued From page 51 cleanable.	F 465		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	**1601 ST LOUIS AVENUE DULUTH, MN 55802**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Bayshore Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Bayshore Health Center is a 2-story building with a no basement. The original building was constructed in 1969 with an addition in 1978. The original building buildings and additions are all Type II (111) construction, therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 140 beds and had a census of 126 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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