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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GYIU

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 **12/08/2014** (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):

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 12/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/12/2014 (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
12/17/14 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/10/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245227

December 12, 2014

Ms. Shelley Katzenburger, Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, Minnesota 55802

Dear Ms. Katzenburger:

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 November 25, 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
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 12, 2014

Ms. Shelley Katzenburger, Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, Minnesota 55802

RE: Project Number S5227025

Dear Ms. Katzenburger:

On November 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 24, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 26, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2014, effective November 25, 2014 and therefore remedies outlined in our letter to you dated November 6, 2014, will not be imposed.

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
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5227r15

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing	12/8/2014

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 **F0221** Reg. # **483.13(a)** LSC	**11/21/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**11/21/2014**	ID Prefix **F0258** Reg. # **483.15(h)(7)** LSC	**11/25/2014**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**11/25/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**11/25/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**11/25/2014**
ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	**11/25/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	**11/25/2014**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	**11/25/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**11/15/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**11/25/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**11/25/2014**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	**11/25/2014**	ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PLH/mm	12/12/2014	12835	12/08/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/24/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing **01 - MAIN BUILDING 01**	11/26/2014

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 Reg. # **NFPA 101** LSC K0018	**11/25/2014**	ID Prefix Reg. # **NFPA 101** LSC K0029	**11/25/2014**	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** PS/mm	**Date:** 12/12/2014	**Signature of Surveyor:** 03005	**Date:** 11/26/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/22/2014		**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: GYIU

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 **10/24/2014** (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:

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):

17. SURVEYOR SIGNATURE Date :
Theresa Ament, HFE NEII 11/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/10/2014 (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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6399

November 6, 2014

Ms. Shelley Katzenburger, Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, Minnesota 55802

RE: Project Number S5227025

Dear Ms. Katzenburger:

On October 24, 2014, 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.

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.

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:

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

Plan of Correction - 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 December 3, 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 December 3, 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 January 24, 2015 (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 April 24, 2015 (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:

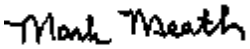
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

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

Sincerely,



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

Enclosure(s)

PRINTED: 11/06/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	10/24/2014

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 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.	F 000	OK 11-25-14 SLH	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R97) with a wheelchair (w/c) seatbelt restraint, was released from the restraint when supervised during meals to maintain the least restrictive device, for the least amount of time. In addition, comprehensive assessments and ongoing monitoring/ evaluation for the use of restraints was lacking for 2 of 2 residents (R97 and R71) observed with w/c seatbelt restraints.	F 221	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Katzenburger	Administrator	11/21/14

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 221	Continued From page 1 Findings include: R97's quarterly Minimum Data Set (MDS) dated 8/14/14, indicated his cognition was severely impaired, he required extensive assistance with all activities of daily living (ADLs) and had a trunk restraint, which was used on a daily basis. R97's care plan revised 8/26/14, included diagnoses of Parkinson's disease, dementia, muscle weakness and difficulty walking. The care plan indicated R97 had an alarmed, self-releasing seatbelt in his w/c which he was unable to release on command. Interventions included discussing the risks/ benefits of this restraint with the resident/ family/ caregivers and evaluating the restraint use quarterly and as needed (PRN). The evaluations were to include assessment and recording of continued risks/ benefits, alternatives tried and the need/ reason for ongoing use of the restraint. The evaluations were also to include assessment of when the restraint was to be applied and released. The care plan identified R97's restraint was to be released every two hours and PRN. The nursing assistant care guide (undated), indicated R97 had an alarmed self-releasing belt in his w/c and instructed staff to release the seatbelt every two hours and while at meals or activities. On 10/23/14, at 8:35 a.m. R97 was observed in the main dining room, sitting in his w/c eating breakfast. Nursing assistant (NA)-L assisted R97 with eating his meal. A Velcro, alarmed seatbelt was observed as fastened, across R97's lower torso. A TABS alarm (a garment clip with a	F 221	**F221** This facility does ensure that residents are free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. 1. <u>Corrective Action:</u> a. The residents in question R97 and R71 were assessed for the appropriateness of continuing the restraint. b. Residents R97 and R71 seat belt restraint were discontinued. c. Nursing staff were educated that seat belt restraints must be released at a minimum every two hours. d. Any resident in the facility with a seat belt has the potential to be affected by this perceived deficient practice. 2. <u>Corrective Action as it applies to other residents:</u> a. An audit of residents was completed to ensure anyone with a seat belt restraint on their wheelchair was re-assessed to	

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F 221	Continued From page 2 pull-string, attached magnetically to an alarm) was also observed hanging on the back of the w/c with the clip attached to the back of R97's shirt. At 8:48 a.m., NA-H took over and continued feeding R97. At 8:56 a.m., R97 had finished eating and was assisted in his w/c to the nurses' station. The Velcro, alarmed seatbelt was not released while R97 was supervised, throughout the entire breakfast meal. On 10/23/14, at 9:49 a.m. NA-H stated R97 used to occasionally open his seatbelt, but had not been able to open it "for a while." On 10/23/14, at 12:15 p.m. R97's family member (F)-A was observed in the dining room, assisting R97 with eating the lunch meal. F-A stated R97 had the alarmed seatbelt "for a while" and it was not removed when supervised during meals. F-A stated she visited often and had never observed staff remove the seatbelt during meals. F-A added, R97 used the seatbelt because he tried to stand up. At that time, it was noticed R97 no longer had the seatbelt in his w/c. F-A stated she was unsure what had happened to the seatbelt and was unaware the belt had been removed. On 10/23/14, at 2:30 p.m. registered nurse (RN)-A (RN supervisor) stated the seatbelt had been removed and discontinued. An inquiry was made regarding an assessment for the removal of the device and RN-A stated she would "look into it." RN-A stated she was unable to locate the initial and quarterly assessments related to R97's restraint use and was unsure how long R97 had the seatbelt in place. RN-A confirmed the	F 221	ensure the restraint continued to be appropriate. b. Any resident whose assessment determined the seat belt restraint could be discontinued had the restraint discontinued. c. Nursing staff were re-educated that seat belt restraints must be released at a minimum every two hours. 3. Reoccurrence will be prevented by: a. Random audits of persons with seat belts will be completed to ensure that restraint release is occurring per policy. 4. The correction will be monitored by: a. The process for compliance will be monitored by the DON, ADON's and designees with oversight by Nursing Home Administrator. b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 11/21/14	

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F 221	Continued From page 3 seatbelt should have been removed when supervised during all meals. R97's medical records were reviewed and lacked evidence of an assessment for this restraint, to indicate when the restraint was initiated and to identify the reason for the restraint. There was no physician's order for the restraint and no indication as to what other alternatives may have been attempted prior to initiation of the restraint. Further, ongoing monitoring/ quarterly evaluations to determine the continued need for use of the restraint was lacking. An assessment regarding removal of the seat belt was requested, but not provided. R7's undated Admission Record identified diagnoses including dementia and epilepsy. The quarterly MDS dated 10/13/14, indicated R7's cognition was severely impaired. The MDS identified he had no hallucinations or delusions, but did exhibit behaviors that included physical behavioral symptoms directed at others and wandering. The MDS further identified R7 required extensive assistance for bed mobility, wheelchair locomotion, transfers and ambulation. The MDS did not identify R7's use of a Velcro seatbelt or the use of a trunk restraint. R7 was observed on 10/21/14, at 9:31 a.m. with a Velcro seatbelt secured across his waist while he was seated in his w/c. R7's care plan revised 10/22/14, indicated a Velcro alarmed, self-releasing seatbelt was used while he was in his w/c for fall prevention. The	F 221		

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F 221	Continued From page 4 seatbelt was noted as not restraining for R7, as he could release the seatbelt when directed to do so. On 10/23/14, at 8:46 a.m. RN-A was interviewed and stated R7 was able to remove his Velcro seatbelt on command. RN-A stated she reviewed the use of the Velcro seatbelt every quarter, but was unable to provide evidence of these assessments/ reviews. On 10/23/14, at 11:05 a.m. R7 was observed in RN-A's office. RN-A stated she was attempting to see if R7 could remove his Velcro seatbelt on request. RN-A then directed R7 to open the seatbelt several times. R7 was unable to respond to her verbal commands. On 10/24/14, at 9:30 a.m. the director of nursing (DON) was interviewed and stated a Velcro seatbelt should have been assessed quarterly or with a change in condition. The facility's Use of Restraints policy revised 2/14, indicated restraints were used for the safety and well-being of the residents and were implemented only after other alternatives had been tried unsuccessfully. Restraints were to be used to treat a resident's medical symptom, but were never to be used for discipline, staff convenience, or for the prevention of falls. The policy included a chair that prevented rising as an example of a restraint. The policy further indicated prior to placing a resident in restraints, a pre-restraining assessment and review to	F 221		

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F 221	Continued From page 5 determine the need for the restraint was to be completed. The policy added, a physician's order was also to be obtained. Restrained individuals were to be reviewed at least quarterly to determine whether they were candidates for a restraint reduction, less restrictive method of a restraint, or total restraint elimination. The policy directed restraints were to be released at least every two hours; however, the policy did not identify removal of restraints during supervised times, such as meals/ activities.	F 221	**F253** This facility does housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. Corrective Action: a. R37's wheelchair was cleaned. b. Any resident that uses a wheelchair in the facility has the potential to be affected by this perceived deficient practice.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident wheelchairs remained clean and maintained, for 1 of 40 residents (R37) observed with a soiled wheelchair. Findings include: On 10/21/14 at 9:17 a.m. R37's wheelchair was observed to be soiled with dirt and debris. During the environmental tour with the Director of Maintenance (DOM) and the Director of Environmental Services (DES) on 10/23/14, at 11:00 a.m. R37's wheelchair was again observed	F 253	2. Corrective Action as it applies to other residents: a. An audit was done of resident wheelchairs to ensure all resident wheelchairs were clean. b. Nursing staff were educated that wheelchair cleaning is to be done as per schedule and whenever noticeably soiled. 3. Reoccurrence will be prevented by: a. A schedule will be developed and posted for resident wheelchairs to be cleaned for the residents and whenever noticeably soiled.	

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F 253	Continued From page 6 as soiled, with dirt/ debris. Under the right-side arm rest, a large dried puddle of brown liquid was observed. DOM and DES verified the findings. DES stated the resident wheelchairs were cleaned by nursing and she was unsure how often the cleaning was done.	F 253	4. <u>The correction will be monitored by:</u> a. Audits will be conducted by the DON, ADON or designee to ensure wheelchairs are clean. b. The process for compliance will be monitored by the DON, ADON's and designees with oversight by Nursing Home Administrator. c. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. <u>Date of Completion: 11/21/14</u>	
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comfortable sound levels during mealtimes in the facility's memory care dining room. This had the potential to affect 15 of 15 residents who ate in that dining room. Findings include: During observation of the supper meal in the memory care dining room on 10/20/14, from 5:38 p.m. through 6:19 p.m., the noise level was noted to be loud. One resident yelled out loudly during the meal, while another resident yelled out, but was not as loud. The radio was playing classic rock music. Two residents complained they could not converse because they were unable to hear	F 258		

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F 258	Continued From page 7 one other. Another resident started slapping the table with her hand and then bit the palm of her hand. Once the meal arrived, that same resident began to slam her food tray loudly on the table. On 10/20/14, at 5:40 p.m. registered nurse (RN)-G was interviewed and stated the dining room had been this loud for the last week or two. RN-G added, the choice of classic rock music was appropriate for the dining meal. During observation of the breakfast meal in the memory care dining room on 10/21/14, from 8:12 a.m. through 9:02 a.m., the noise level was again noted to be loud. One resident yelled loudly, while the radio was playing classic rock music. Another resident stated to her tablemate, "He is one noisy creature," to which her tablemate replied, "I can't hear you." Another resident was pounding her beverage cup on the table, while a different resident was pounding his fork onto his plate. On 10/24/14, at 9:30 a.m. the director of nursing (DON) was interviewed and verified the noise level in the memory care dining room was to be kept to a minimum. The undated facility Dining Atmosphere policy directed the meal was to be served in a way which enhanced the dining experience.	F 258	**F258** This facility does provide for the maintenance of comfortable sound levels. 1. Corrective Action: a. The nurse on the memory care unit was educated to ensure appropriate music at a level to maintain resident comfort. b. Nursing staff were educated to ensure that any resident demonstrating disruptive behaviors that could disrupt the dining experience are acted on per care plan which may require relocation to dine in an alternate area. c. Any resident on the memory care unit has the potential to be affected by this perceived deficient practice. 2. Corrective Action as it applies to other residents: a. Nursing staff were educated to ensure appropriate music at a level to maintain resident comfort in the dining room.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279	3. Reoccurrence will be prevented by: a. Random audits of dining rooms will be conducted by DON or designee	

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F 279	Continued From page 8 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop resident care plans to address the use of Coumadin (an anticoagulant medication) and Lantus (insulin), for 1 of 5 residents (R7) whose medications were reviewed. Findings include: R7's current physician orders dated 10/24/14, directed Coumadin, 2 milligrams (mg) on Tuesdays and Thursdays and 1 mg per day for the remainder of the week, for a diagnosis of atrial fibrillation. The orders also directed Lantus SoloStar Insulin, injecting 20 units	F 279	to monitor the noise level. 4. The correction will be monitored by: a. The process for compliance will be monitored by the DON, ADON's and designees with oversight by Nursing Home Administrator. b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 11/25/14	

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F 279	Continued From page 9 subcutaneously each day, for a diagnosis of diabetes. R7's care plan initiated 12/20/13, lacked indications for use and monitoring of side effects for his use of Coumadin and Lantus. On 10/24/14, at 9:30 a.m. the director of nursing (DON) was interviewed. The DON confirmed the use of Coumadin and Lantus should have been addressed on R7's care plan. The facility's Care Plans - Comprehensive policy revised 10/10, directed an individualized comprehensive care plan that included measurable objectives and timetables to meet each resident's medical, nursing, mental and psychological needs.	F 279	**F279** This facility does assess residents using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months and uses the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 1. Corrective Action: a. Resident R7's care plan was reviewed and updated to include monitoring for signs and symptoms of bruising and/or bleeding. b. Resident R7's care plan was reviewed and updated to include monitoring of blood sugar results with reporting parameters as indicated. c. Any resident in the facility with a Coumadin or insulin order has the potential to be affected by this perceived deficient practice.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	2. Corrective Action as it applies to other residents: a. Residents in the facility receiving insulin or anticoagulant therapy were identified and care plans were	

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F 280	Continued From page 10 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident care plan was revised to reflect current urinary catheter needs for 1 of 1 resident (R97) reviewed for urinary catheter use. The facility also failed to ensure a resident care plan was updated to reflect current emergency contacts and communication practices for 1 of 1 resident (R50) who required service coordination between the facility and a dialysis unit, for end stage renal disease (ESRD). Findings include: R97's catheter care plan revised 8/26/14, identified he had a suprapubic catheter (a tube inserted through the belly and into the bladder) due to a history of urinary retention and an enlarged prostate (BPH) which was placed on 9/01. The care plan directed staff to use an abdominal binder every shift to prevent from pulling on the catheter. The care plan also included direction for using appropriate infection control practices, including proper hand washing, catheter care, tubing and drainage bag care. The tubing and drainage bag care directed staff to keep the drainage bag below the level of the	F 280	reviewed and revised as indicated. 3. Reoccurrence will be prevented by: a. Resident care plans will be updated quarterly and annually and with any significant change. b. Nursing staff were re-educated on medication monitoring as it specifically relates to those individuals on Coumadin and insulin. 4. The correction will be monitored by: a. Audits will be conducted by the DON or designee to ensure care plans are reviewed and updated per policy. b. The process for compliance will be monitored by the DON, ADON's and designees with oversight by Nursing Home Administrator. c. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 11/25/14	

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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 _____	10/24/2014

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 280	Continued From page 11 bladder and keep it off the floor, using a covered bag while up in his wheelchair (w/c), anchoring the catheter to avoid excessive tugging during treatments and cares. The care plan directed the catheter bag be drained every two hours. The undated nursing assistant (NA) care sheet also directed staff to drain the catheter every two hours. On 10/22/14, at 9:49 a.m. NA-H was observed to drain R97's urinary catheter. During the procedure it was noted, R97 did not have an abdominal binder covering the catheter, nor a drainage bag connected to the catheter tubing. The end of the tubing was plugged with a cap. NA-H stated R97 did not use a drainage bag; however, he had been recently hospitalized and did have a drainage bag for a short period of time upon return from the hospital. NA-H did not mention if R97 ever had an abdominal binder. R97's current physician orders dated 10/4/14, directed staff to leave the Foley (catheter) attached to a bag for two days then go back to capping the Foley and intermittent drainage. On 10/23/14, at 9:03 a.m. NA-I drained R97's suprapubic catheter. There was no abdominal binder and drainage bag attached to the catheter. NA-I stated R97 had not used a drainage bag for "a long time." NA-I did not mention if R97 ever had an abdominal binder. On 10/23/14, at 3:26 p.m. registered nurse (RN)-A (the nurse supervisor) verified R97's care	F 280	**F280** This facility does afford residents the opportunity to participate in planning care and treatment or changes in care and treatment. 1. Corrective Action: a. Resident R50's care plan was reviewed and updated to include his choice not to use the "communication book" as a means of communication between the facility and the dialysis unit. b. Resident R97's care plan was reviewed and updated to reflect his current catheter needs. c. Any resident in the facility on hemodialysis or urinary catheters have the potential to be affected by this perceived deficient practice. 2. Corrective Action as it applies to other residents: a. All residents in the facility receiving hemodialysis or with urinary catheters were identified and care plans were reviewed and revised as indicated. b. The policy and procedure for revision of care plans to reflect the care provided were reviewed.	

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F 280	Continued From page 12 plan did not reflect his current catheter care needs. RN-A stated she knew he had the catheter for a long time and had no routine drainage bag. The comprehensive care plan policy revised 10/10, indicated an individualized comprehensive care plan would be developed to meet the resident's medical, nursing, mental, and psychological needs. The policy did not address how revisions in the care plan would be completed to reflect current care needs. R50's Diagnosis Report dated 10/24/14, included a diagnosis of stage four (severe) chronic kidney disease. The quarterly Minimum Data Set (MDS) dated 9/11/14, indicated R50 had no cognitive impairment and received dialysis. R50's dialysis care plan dated 12/27/13, indicated he had the potential for complications from dialysis, including shortness of breath, chest pain, edema, elevated blood pressure, infected or occluded access area, nausea and vomiting. The care plan directed facility staff to communicate/ coordinate R50's services by sending a report on his current health status via a communication book. Facility staff were instructed to check the book upon return to the facility for updates, orders, etc. The care plan lacked current contact information and telephone numbers for dialysis related emergencies. The care plan also lacked updated information on how communication was to occur between the facility and the dialysis center, how often the communication was to take place and where the communication was to be recorded, given the communication book was no longer utilized per R50's request.	F 280	3. <u>Reoccurrence will be prevented by:</u> a. Resident care plans will be updated quarterly and annually and with any significant change. b. Newly admitted residents receiving hemodialysis will have the dialysis emergency contact on their care plan. c. Newly admitted residents or existing residents with catheters will have current catheter needs reflected on their care plan. d. Nursing staff were re-educated on the policy/procedure for Preliminary, Comprehensive Care Plans, Care of the resident with End Stage Renal Disease and Urinary tract infections. 4. <u>The correction will be monitored by:</u> a. Audits will be conducted by the DON or designee to ensure care plans of persons on hemodialysis and/or with catheters are reviewed and updated per policy. b. Resident care plans will be updated at the time of resident care conferences or with significant changes involving hemodialysis and/or catheters with random	

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F 280	Continued From page 13 On 10/23/14, at 3:20 p.m. RN-C stated that in an emergency for R50, she would have called the hospital or the on-call doctor. RN-C did not know if a communication book went with R50 to and from dialysis. On 10/23/14, at 3:25 p.m. R50 stated he no longer used a communication book when going to and from dialysis, "Because nobody ever wrote in it so I quit using it." On 10/24/14, at 8:30 a.m. RN-B stated laboratory results were faxed to the dialysis center. RN-B stated R50 had a communication book that was sent to and from dialysis for care coordination. If R50 was unable to go to dialysis she stated she would have called the dialysis clinic. On 10/24/14, at 9:11 a.m. the health unit coordinator (HUC) stated she had never seen a communication book for R50. The HUC confirmed she was usually present when R50 returned from dialysis and he had never given her a communication book. The HUC reported R50 had never relayed information about his dialysis, other than to report if he was having pain and wanted a pain pill. On 10/24/14, at 9:20 a.m. the director of nursing (DON) stated R50 did not want to carry the communication book to and from dialysis. If dialysis had anything to communicate, they sent a note back with R50 or called the facility to relay	F 280	audits completed by the DON or designee. c. The process for compliance will be monitored by the DON, ADON's and designees with oversight by Nursing Home Administrator. d. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 11/25/14	

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F 280	Continued From page 14 the information. The DON verified the emergency contact numbers were not included on the care plan. The DON also verified the care plan directed staff to send and receive a communication book to coordinate services with R50's dialysis center. The facility's Care of the Resident with End Stage Renal Disease (ESRD) policy revised 10/10, indicated agreements between the facility and the dialysis center were to include an explanation of how information was to be exchanged between the facility and the dialysis center. The policy also directed the care plan was to reflect the resident's needs related to ESRD/ dialysis care.	F 280	**F282** This facility does ensure that residents are provided care by qualified persons in accordance with each resident's written plan of care. 1. Corrective Action: a. Nursing assistant care guides were audited to ensure they reflected the current plan of care for the residents. b. Nursing staff were educated that seat belt restraints must be released at a minimum every two hours per policy. c. Any resident in the facility has the potential to be affected by this perceived deficient practice. 2. Corrective Action as it applies to other residents: a. An audit of nursing assistant care guides was completed to ensure they reflected the current plan of care for the residents. b. Nursing staff were re-educated that seat belt restraints must be released at a minimum every two hours per policy. 3. Reoccurrence will be prevented by:	
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 ensure 1 of 2 residents (R97) with a seatbelt restraint in his wheel chair (w/c), was released when supervised during meals, as was directed per his written plan of care. Findings include:	F 282		

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F 282	Continued From page 15 R97's care plan revised 8/26/14, indicated he had an alarmed, self-releasing seatbelt in his w/c, which he was unable to release on command. Interventions directed the seatbelt be applied when R97 was in his w/c, releasing the seatbelt every two hours and as needed (PRN). The undated nursing assistant care sheet, identified R97 had an alarmed, self-releasing belt in his w/c and instructed staff to release the seatbelt every two hours and during meals/ activities. On 10/23/14, at 8:35 a.m. R97 was observed in the main dining room, sitting in his w/c eating breakfast. Nursing assistant (NA)-L assisted R97 with eating his meal. A Velcro, alarmed seatbelt was observed as fastened, across R97's lower torso. A TABS alarm (a garment clip with a pull-string, attached magnetically to an alarm) was also observed hanging on the back of the w/c with the clip attached to the back of R97's shirt. At 8:48 a.m., NA-H took over and continued feeding R97. At 8:56 a.m., R97 had finished eating and was assisted in his w/c to the nurses' station. The Velcro, alarmed seatbelt was not released while R97 was supervised, throughout the entire breakfast meal. On 10/23/14, at 9:49 a.m. NA-H stated R97 used to occasionally open his seatbelt, but had not been able to open it "for a while." On 10/23/14, at 12:15 p.m. R97's family member (F)-A was observed in the dining room, assisting R97 with eating the lunch meal. F-A stated R97 had the alarmed seatbelt "for a while" and it was not removed when supervised during meals. F-A	F 282	a. Nursing staff were re-educated that seat belt restraints must be released at a minimum every two hours per policy. 4. <u>The correction will be monitored by:</u> a. Random audits of nursing assistant care guides will be completed to ensure they reflect the current plan of care. b. The process for compliance will be monitored by the DON, ADON's and designees with oversight by Nursing Home Administrator. c. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. <u>Date of Completion: 11/25/14</u>	

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F 282	Continued From page 16 stated she visited often and had never observed staff remove the seatbelt during meals. F-A added, R97 used the seatbelt because he tried to stand up. On 10/23/14, at 2:30 p.m. the RN supervisor (RN)-A confirmed the seat belt should have been removed when supervised during all meals as directed by the care plan.	F 282	**F322** This facility does ensure that a resident who is fed by a naso-gastric or gastronomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 322	1. Corrective Action: a. The facility will ensure that the procedure for administration of medications via the G tube will be adhered to. b. Education was provided immediately to the nurse administering medications to R102. c. Any resident in the facility with a G-tube has the potential to be affected by this perceived deficient practice. 2. Corrective Action as it applies to other residents: a. An audit of residents was completed to ensure anyone with G-tube medications was identified. b. All residents who receive medications via G-tube had their	

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F 322	Continued From page 17 review, the facility failed to ensure a resident's gastrostomy tube (G-tube, a tube to the stomach for feeding) was checked for proper placement prior to medication administration, for 1 of 2 residents (R102) observed for medication administration through a G-tube. Findings include: R102's physician orders revised 4/24/14, indicated she was to receive nothing by mouth and a G-tube was in place. R102's medication orders indicated she was to receive her medications via the G-tube. During an observation on 10/23/14, at 9:09 a.m. registered nurse (RN)-E prepared to administer medications to R102 through her G-tube. RN-E flushed the G-tube with water and administered medications through the G-tube. RN-E did not check for placement of the G-tube, prior to administering the water and medications. RN-E verified she did not check the G-tube for placement. During an interview on 10/24/14, at 9:15 a.m. the director of nursing (DON) verified nurses were expected to check for placement before administering anything through a G-tube and that staff were to follow the facility's policy. The facility's Administering Medications through an Enteral Tube policy revised 12/12, directed nursing to check tube placement prior to	F 322	MAR's corrected to include the procedure for checking placement of the G-tube prior to the administration of medications was added. c. Nursing staff were re-educated that G-tube placement must be checked prior to administering any medications via the G-tube. 3. <u>Reoccurrence will be prevented by:</u> a. Nursing staff were re-educated on the policy to check G-tube placement prior to administering any medications via the G-tube. b. All new nursing staff will be educated on the correct procedure prior to caring for a resident requiring medication administration via G-tube. c. Random observation by DON or Nurse Manager or their designees will be completed to ensure the procedure is followed. 4. <u>The correction will be monitored by:</u> a. The process for compliance will be monitored by the DON, ADON's and designees with oversight by Nursing Home Administrator.	

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F 322	Continued From page 18 administering medications via a G-tube. The procedure provided step-by-step instructions on checking the tube for placement.	F 322	b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review.	
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, 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 interview and document review, the facility failed to identify weight loss for 1 of 3 residents (R7) who experienced significant weight loss. Findings include: R7's undated Admission Record identified diagnoses including dysphagia (difficulty swallowing). Review of his medical record from 4/20/14, through 10/20/14, revealed the following weights:	F 325	5. Date of Completion: 11/25/14	

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F 325	Continued From page 19 . On 4/21/14, R7 weighed 119 pounds. . On 5/21/14, R7 weighed 109 pounds, a significant weight loss of 8.4% in 30 days. . On 6/6/14, R7 weighed 116 pounds. . On 7/18/14, R7 weighed 120 pounds. . On 8/1/14, R7 weighed 112 pounds, a significant weight loss of 6.7% in 15 days. . On 8/14/14, R7 weighed 112 pounds. . On 9/6/14, R7 weighed 110 pounds. . On 10/7/14, R7 weighed 108 pounds, a significant weight loss of 11.1% in 90 days. R7's nutrition assessment dated 7/21/14, indicated he received a pureed diet, with pudding thick liquids. His average intake was noted as 50-75%. The nutrition assessment further identified R7 at risk for malnutrition and dehydration. R7's weight was to be monitored monthly for significant changes. R7's care plan revised 7/21/14, indicated his goal was to sustain adequate nutritional status by maintaining his weight within 5% of 120 pounds (114 to 126 pounds). The care plan further directed R7 required pudding consistency liquids and was to receive an evening snack of pudding. R7's quarterly Minimum Data Set (MDS) dated 10/13/14, indicated he required extensive	F 325	**F325** This facility does ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. 1. Corrective Action: a. Resident R71 weight loss was reviewed by the DON, ADON and Dietician. b. Resident R71 was placed on weekly weight monitoring. c. Any resident in the facility with a weight loss has the potential to be affected by this perceived deficient practice. 2. Corrective Action as it applies to other residents: a. An audit of residents was completed to ensure anyone with a significant weight loss was identified, criteria of 5% weight loss in 30 days or 10% weight loss in 180 days was used. b. Any resident with identified weight loss or at risk for weight loss will have a nutritional risk assessment and will be placed on weekly weight	

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F 325	Continued From page 20 assistance for eating, had no signs/ symptoms of a swallowing disorder, was on a mechanically altered diet and was to receive a therapeutic diet. The MDS further noted R7's weight was 118 pounds, with no weight loss identified. On 10/24/14, at 9:50 a.m. the certified dietary manager (CDM)-H was interviewed and stated R7 had been losing weight the past four months. The CDM-H stated the consulting dietician had informed the facility of R7's weight loss on 10/23/14, and directed the facility to initiate weekly weights. The facility was unable to provide a policy and procedure regarding residents at nutritional risk.	F 325	monitoring. 3. Reoccurrence will be prevented by: a. Dietician, DON, and ADON will review weekly weights at weekly IDT meetings to determine new interventions to prevent further weight loss as possible. 4. The correction will be monitored by: a. The process for compliance will be monitored by the Dietician, DON, ADON's and designees with oversight by Nursing Home Administrator. b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 11/25/14	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		

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F 334	Continued From page 21 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal	F 334	**F334** This facility does ensure that residents receive influenza vaccines annually. 1. Corrective Action: a. The residents in question R76 and R128 will be offered influenza immunizations during the 2014 – 2015 flu season. b. The facility will identify residents who have not received a flu shot in 2014. c. The policy and procedure for influenza vaccine and seasonal prevention and control was reviewed. d. Any resident in the facility has the potential to be affected by this perceived deficient practice. 2. Corrective Action as it applies to other residents: a. An audit of residents, charts, contact with providers and review of MICC system to determine status of the vaccination administration records will be completed for all residents in the facility. b. Any resident who does not have evidence of vaccination elsewhere was offered and encouraged to get	

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F 334	Continued From page 22 immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure 2 of 5 residents (R76 and R128) were provided education and given the opportunity to receive or decline an influenza vaccination during the 2013, to 2014, annual influenza vaccination season. Findings include: R76 was admitted to the facility on 7/7/13. The facility's undated Immunization Report indicated R76 last received an influenza vaccination on 11/15/12: R128 was admitted to the facility on 10/31/12. The facility's undated Immunization Report indicated R128 last received an influenza vaccination in 2012, with no day or month specified. R76 and R128's medical records lacked evidence they were provided education regarding the benefits/potential side effects of the influenza vaccination for the 2013, to 2014, influenza season. The medical records also lacked evidence they were offered, received and/or	F 334	the flu shot unless their physician determines it is medically contraindicated. c. New admissions during the 2014 – 2015 flu season who does not have evidence of vaccination elsewhere will be offered and encouraged to get the flu shot unless their physician determines it is medically contraindicated. 3. Reoccurrence will be prevented by: a. Newly admitted residents will be assessed for status of influenza immunizations to determine need for current season. b. Any resident identified as needing an influenza vaccination will be offered the vaccine per facility policy. c. Nursing staff were re-educated on the facility policy/procedure relating to influenza vaccination. d. Refusals of influenza vaccination will be documented per facility policy. 4. The correction will be monitored by: a. The process for compliance will be monitored by the Infection control	

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F 334	Continued From page 23 refused an influenza vaccine during the 2013, to 2014, influenza season. On 10/24/14, at 8:52 a.m. the director of nursing (DON) stated the facility had not yet offered the influenza vaccine to residents for the 2014, to 2015, influenza season, as the vaccine was just received by the facility on 10/23/14. The DON confirmed all residents were to be offered the vaccine annually. On 10/24/14, at 10:00 a.m. the director of medical records (DMR) verified there was no documentation in R76 and R128's medical records to indicate the influenza vaccine had been offered or refused during the 2013, to 2014, influenza season. The Influenza Vaccine policy revised 12/12, directed all residents without medical contraindications were to be offered the influenza vaccine annually, between 10/1, and 3/31, of each year. Education regarding the benefits and potential side effects were to be provided annually as well. The policy instructed the provision of education and refusal of the vaccine was to be documented in the resident's medical record.	F 334	specialist, DON, ADON's and designees with oversight by Nursing Home Administrator. b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 11/25/14	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.	F 356		

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F 356	Continued From page 24 o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the daily nursing hours posting included the actual hours worked by licensed and unlicensed staff. This had the potential to affect all 120 residents who resided in the facility. Findings include:	F 356	**F356** This facility does ensure that nurse staffing posting includes actual hours worked for licensed and unlicensed direct care staff. 1. Corrective Action: a. The staffing posting for direct care staff working was modified to include the actual hours worked for the shift. b. Any resident in the facility has the potential to be affected by this perceived deficient practice. 2. Corrective Action as it applies to other residents: a. The staffing posting for direct care staff working was modified to include the actual hours worked for the shift. 3. Reoccurrence will be prevented by: a. Continued use of modified form for posting direct care staff working. 4. The correction will be monitored by: a. The process for compliance will be monitored by the HR director and	

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F 356	Continued From page 25 During the initial tour on 10/20/14, at 11:58 a.m. the nursing hours posting was observed on a wall, to the side of the front desk. The nursing hours posting lacked the actual hours worked by licensed and unlicensed staff. On 10/22/14, at 7:27 a.m. the daily posting again lacked the actual hours worked by licensed and unlicensed staff. On 10/24/14, at 10:23 a.m. the daily posting was observed in the same location, lacking the actual hours worked by licensed and unlicensed direct staff. During an interview on 10/24/14, at 9:15 a.m. the director of nursing (DON) stated the human resource department was responsible for the completion of the nursing hours posting and verified the posting did not include the actual hours worked for licensed and unlicensed staff. The facility's Posting Direct Care Daily Staffing Numbers revised 8/06, directed shift staffing information on the direct care staff, be posted in a prominent location available to residents and visitors. The policy instructed the posting was to include the actual time worked during that shift, for each category and type of nursing staff.	F 356	designees with oversight by Nursing Home Administrator. b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 11/15/14	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 26 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 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	F 441	**F441** This facility does have an infection control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. 1. Corrective Action: a. The facility appointed an Infection Preventist who will have oversight and responsibility of the Infection Control Program. A system will be in place to monitor and investigate causes of infection (Nosocomial – facility acquired and community acquired) and look at the manner of which infections are spread. A record will be kept that identifies each resident with an infection – date of onset – cause – site of infection – preventive actions taken to spread within the facility. b. A monthly log will be kept – and noted by location and type of infection. A rate will be determined at the end of each month. Infection in Long Term Care will review high prevalence of infections, high rates of colonization with antimicrobial	

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F 441	Continued From page 27 review, the facility failed to implement an infection control surveillance plan to identify, document and monitor resident infections. Appropriate personal protective equipment (PPE) and hand hygiene were not utilized during personal care observed for resident (R54) who was on contact precautions, and for R97 observed for catheter care; the multi-use glucometer (machine used to check blood sugar with a blood sample) was not sanitized after use for R45; personal care supplies were at risk for contamination due to being stored on the back of the toilet for R71 and R111. This had the potential to affect all 120 residents who resided in the facility. Findings include: FACILITY SURVEILLANCE: The facility's Daily Infection Logs for the months of 9/14, and 10/14, lacked evidence to support signs and symptoms of resident infections and culture reports/results were included in the facility's infection control surveillance system. Information was not available to track and trend signs/ symptoms of potential infections within the facility. In addition, there was no system to identify whether cultures had been ordered to identify the infectious organism in order to determine appropriate antibiotic usage. On 10/24/14, at 10:25 a.m. registered nurse (RN)-A (nurse supervisor) was interviewed regarding the facility's infection control surveillance system. RN-A stated the infection control logs were completed daily and were brought to the facility's quality assessment and	F 441	resistant microbes, frequent and inappropriate prescribing of antimicrobials, and appropriate coordination of clinical and nursing care. The process and surveillance will be done on a monthly basis. c. A key element in the Infection Control program will include appropriate training related to hand washing, isolation and precautions, employee and resident health and use of PPE (Personal Protective Equipment). Evidence based Infection Control Surveillance is completed using the McGeer Criteria. d. In addition a review has been completed on policies and procedures as it relates to regulatory requirements – facility management including environmental control, disinfection, and asepsis. The overall infection control findings are part of the monthly Quality Assurance and Performance Improvement meeting. e. Employees who have any type of illness will be identified and the spell of illness will be tracked to determine if the illness requires	

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F 441	Continued From page 28 assurance (QA&A) meetings monthly. RN-A confirmed the logs did not include specific signs/ symptoms of resident infections or identification of the specific infectious organisms. RN-A stated the facility monitored those areas in the past, but had discontinued that practice. A policy regarding the facility infection control surveillance program was requested; however, no policy was provided. CONTACT PRECAUTIONS R54's care plan revised 10/21/14, indicated she required extensive assistance with activities of daily living, including toilet use and personal hygiene. In addition, the care plan indicated R54 was frequently incontinent of urine, had a methicillin resistive staphylococcus aureus (MRSA) infection in the urine and was on contact isolation precautions for infection control purposes. The care plan directed staff to glove and gown for all direct contact with bodily fluids. A urinalysis and culture dated 9/12/14, confirmed R54 had MRSA in the urine. From 10/20/14 through 10/22/14, R54 was observed to have a three-drawer, plastic cabinet and a sign directing staff to clean their hands when entering and leaving the room, placed outside the door of her resident room. The sign instructed staff to follow standard precautions and gown and glove when entering the resident room. R54's room did not have a linen hamper or a waste container, other than the standard waste basket.	F 441	quarantine from working with residents or if the illness requires reporting of any nature to local authorities. New employees will be trained during orientation regarding the infection control policies and procedures. Facility staff will be trained on infection control practices to include isolation policies and procedures. f. The Assistant director of Nurses have been trained on the above processes. g. Based on the alleged findings facility staff have been educated on isolation procedures with a focus on implementation and practice of standard precautions including initiating transmission based precautions. h. Nursing staff were re-trained on identifying healthcare associated infections. i. The facility initiated a new signage program for isolation and facility staff were educated on the new process. j. The employee who did not ensure the blood glucose meter was disinfected was immediately educated on the procedure for	

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F 441	Continued From page 29 During observation on 10/21/14, at 9:00 a.m. licensed practical nurse (LPN)-A entered R54's room to administer medications. The plastic cabinet and sign instructing staff to gown and glove before entering the room were observed outside the door of R54's room. LPN-A did not gown or glove upon entering the room or during the administration of medications to R54. LPN-A handled cups and other items on R54's over-the-bed table. Her uniform was also observed to come in contact with R54's bed. LPN-A did not wash or sanitize her hands when she left the room. LPN-A went to the medication cart and touched the computer and other items on the cart. LPN-A stated she did not know why R54 was on precautions and that she would have worn a gown and gloves, but did not realize R54 was on precautions. LPN-A removed keys from a pocket on her uniform and proceeded to open a drawer on the medication cart. At that time, LPN-A was interviewed regarding washing or sanitizing her hands when leaving a room with precautions. LPN-A verified she should have sanitized her hands prior to leaving the room and should have sought out more information about R54's infection control precautions. LPN-A then sanitized her hands. On 10/21/14, at 9:04 a.m. nursing assistant (NA)-C was observed to enter R54's room without a gown or gloves. NA-C was then interviewed and stated she did not touch R54 during this interaction. NA-C added, she thought R54's MRSA was in a hand, but needed to check with the nurse manager to confirm. NA-C verified she should have been more informed and needed to	F 441	cleaning and contaminated items were disposed of. k. Nursing staff were educated on the procedure for disinfecting the blood glucose meter per manufacturer's guidelines. l. Employees were educated on hand washing/hand hygiene. 1. Corrective Action as it applies to other residents: a. The infection control specialist has changed the identification system of persons on contact precautions based on CDC guidelines. b. All staff were educated on the new identification system of persons on contact precautions. 2. Corrective Action as it applies to other residents: a. Residents who reside at Bayshore have the potential to be affected by this perceived practice violation as it relates to infection control. 3. Reoccurrence will be prevented by: a. Monitoring and identifying healthcare associated infections through an active surveillance program.	

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F 441	Continued From page 30 find out more information regarding the purpose of R54's contact precautions. At 10:10 a.m., NA-C returned and stated she had talked with the RN and found out the MRSA was in R54's urine. She added, she was told to wear a gown and gloves when entering R54's room so she could be prepared to do cares. During observation on 10/22/14, at 8:55 a.m. NA-C brought R54 a breakfast tray. At 8:56 a.m. NA-C exited the room without washing her hands. At 8:57 a.m. NA-C entered the room again with a towel and again did not don a gown or gloves or wash her hands prior to entering the room and did not wash or sanitize her hands before exiting the room. On 10/22/14, at 8:56 a.m. maintenance staff (MS)-B approached R54's room, donned a gown and gloves and entered R54's room carrying tools and a hand sanitizer dispenser. MS-B exited R54's room wearing the gown and gloves, placed the tools and a hand sanitizer dispenser on the floor across the hall, removed gloves and the gown while in the hall, opened the utility room door with the door knob and placed the gown and gloves in the bins in the soiled utility room, next to R54's room. MS-B did not wash or sanitize his hands before exiting the soiled utility room. On 10/22/14, at 9:32 a.m. the social worker (SW)-B entered R54's room and did not don a gown or gloves or wash her hands. At 9:40 a.m. SW-B exited R54's room carrying a breakfast tray on her left forearm and entered the elevator to a lower level of the facility.	F 441	b. The facility initiated a new signage program for isolation and facility staff were educated on the new process. c. Spot checking knowledge levels of staff members understanding of Standard Precautions. d. Monitoring staff level understanding regarding isolation procedures with a focus on implementation and practice of standard precautions, including initiating transmission based precautions. e. The staff have been re-trained on acceptable cleaning of the blood glucose meter and process for appropriate cleaning materials per manufacturer's guidelines. 4. Reoccurrence will be prevented by: a. Compliance will be monitored by the Director of Nurses and/or designee with oversight by the facility Administrator. Identified variances will be reported through the facility quality assurance and performance improvement team. 5. Date of Completion: 11/25/14	

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F 441	Continued From page 31 On 10/22/14, at 1:00 p.m. NA-C, stated she had just received clarification yesterday on R54's contact precautions, NA-C stated, "You only need to glove and gown if doing your cares. [R54] has MSRA in her urine. You do not need to gown and glove when bringing in the meal tray." NA-C did verify she should have used hand sanitizer before exiting the room. On 10/22/14, at 1:15 p.m. SW-B stated R54 had MRSA in her urine. SW-B added, "You don't need to gown and glove if you are not doing cares." SW-B stated she sanitized her hands upon leaving the room with the sanitizer in her pocket or on the wall. SW-B confirmed she brought R54's meal tray from the resident room to the facility kitchen. During an interview on 10/23/14, at 4:09 p.m. the DON verified, when a resident was on contact precautions, staff were expected to wear gloves, gowns and masks when coming in contact with bodily fluids. The DON further verified staff should have been aware of infections and proper precautions required when a sign and bin were placed outside a resident's door to indicate special precautions were necessary. In addition, the DON verified staff were to wash hands prior to gloving and after removing gloves. The DON stated there was daily communication through morning report, a communication board, and 24 hour report, where resident infections and necessary precautions were communicated.	F 441		

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(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 441	Continued From page 32 On 10/24/14, at 8:35 a.m. MS-B stated he had been trained on what to do when going into a room with precautions but it had been a long time and the training was probably a bit outdated. MS-B did not know what R54 was on precautions for and was just following what the sign outside the door directed. MS-B stated it did not make sense to him to remove the gown and gloves and sanitize his hands prior to leaving the room. MS-B verified he came out of the room wearing the gown and gloves and placed the tools on the floor across the hall and did not wash or sanitize his hands after removing the gown and gloves in the soiled utility room. The facility policy and procedure for standard precautions revised 12/07, directed staff to wear gloves while in direct contact with a resident who was infected or colonized with organisms that were transmitted by direct contact, including MRSA. The policy directed staff to wear a gown during procedures and resident care activities that were likely to generate splashes or sprays of blood, body fluids, secretions/ excretions or cause soiling of clothing. The policy and procedure further directed staff to remove the gown and perform hand hygiene before leaving a resident's room and after removing gloves. The facility's Isolation- Initiating Transmission Based Precautions policy revised 4/12, indicated an appropriate linen barrel or hamper and waste container with the appropriate liner was to be placed in or near the resident's room. GLUCOMETER DISINFECTION: During observation on 10/22/2014, at 8:24 a.m.	F 441		

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	245227	A. BUILDING _____ B. WING _____	10/24/2014

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F 441	Continued From page 33 RN-B performed a blood sugar (BS) check for R45 with a glucometer that was used for multiple residents. Following the BS check, RN-B placed the glucometer in a box with multiple, clean lancets which were in a plastic supply carrier and brought it to the medication cart. She then removed the glucometer and placed it on the medication cart. RN-B did not disinfect the glucometer after using it with R45 and before placing it with the clean lancets, which were to be used for multiple residents. RN-B reported nurses were to clean the glucometer between residents, stating she usually cleaned it both before and after each use. RN-B verified she should have cleaned the glucometer prior to placing it in the box. RN-B then wiped the glucometer with a hand sanitizing wipe and placed it back in the lancet box. On 10/22/14, at approximately 10:15 a.m. the director of nursing (DON) was informed of the potential contamination of the lancets from the glucometer before it had been disinfected. The DON verified the glucometer should have been cleaned after use and before it was placed with clean supplies. The facility provided the undated manufacturer's policy and procedure for cleaning the glucometer. The procedure lacked direction for when the glucometer was to be cleaned, but did provide guidelines for how to clean the glucometer. The manufacturer's policy and procedure specified the glucometer was to be cleaned and disinfected either with an EPA (Environmental Protection Agency)-registered disinfectant, detergent or germicidal wipe. The policy also included an	F 441		

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F 441	Continued From page 34 option to clean or disinfect with a bleach-containing wipe, with a 1:10 dilution ratio. The hand sanitizing wipe used by RN-B to clean the glucometer did not meet these manufacturer's guidelines. The facility was unable to provide information regarding the wipes that were to be used to disinfect glucometers used by multiple residents within the facility. ENVIRONMENTAL CONCERNS: On 10/21/14, at 9:33 a.m. observations in the shared resident bathroom of R71 and R111 revealed there were incontinent briefs, disposable wipes (including one soiled), two rolls of toilet paper (one unwrapped) and a container of body wash stored atop the toilet tank cover. The toilet seat had no cover, leaving a potential for contamination of these items. R71's fall mat was also observed at this time in his resident room. The mat had five large holes in the covering, approximately 4 x 2 inches in size, resulting in exposed foam from the interior of the mat. The foam surface was un-cleanable, leaving a potential for the spread of infection. On 10/23/14, at 11:00 a.m., during the environmental tour with the director of maintenance (DOM) and the director of environmental services (DES), the following was observed in the shared bathroom of R71 and R111: Incontinent briefs, disposable wipes, two rolls of toilet paper (one unwrapped) and a container of body wash remained stored on the	F 441		

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F 441	Continued From page 35 toilet tank cover. The unwrapped toilet paper had soiled areas, which appeared as splashes of liquid that had dried. DES verified the personal items should not have been stored on the toilet tank cover. DES confirmed potential contamination of the items could have occurred. DES removed the items from the toilet tank cover. Also during the environmental tour, R71's fall mat was again observed. The five holes in the mat remained. DOM and DES verified the findings. DES stated fall mats were to be replaced when worn through. HAND HYGIENE/GLOVE CHANGE WITH CATHETER CARE: R97's suprapubic catheter care was observed on 10/23/14, at 9:03 a.m.. NA-I obtained linens from a linen cart in the hallway and brought the linens into R97's room. NA-I then applied gloves, but did not complete hand hygiene prior to donning the gloves. NA-I proceeded to assist R97 in his wheelchair (w/c) to the bathroom and transferred him onto the toilet. NA-I verbalized the front of R97's incontinent product was significantly wet. She lifted his shirt and examined the suprapubic catheter site. Without changing gloves, NA-I grasped the bathroom door knob and exited bathroom. While outside of the bathroom, NA-I obtained an incontinent product from R97's bottom dresser drawer, obtained a disposable wipe from a container on the bedside dresser, opened the resident room door using the door knob (to ask another staff to bring her a wash cloth), re-entered the bathroom and discarded R97's wet incontinent product. At that time, NA-I disposed of her gloves and applied new gloves. NA-I did not complete hand hygiene between changing her gloves. NA-I was then observed to obtain an alcohol wipe and pinched R97's	F 441		

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F 441	Continued From page 36 catheter line. She wiped the outside of the line and plugged it with the wipe. NA-I then removed the plug from the end of the catheter. While holding the catheter plug in her left, gloved hand, NA-I drained the catheter into a plastic graduate. Minimal urine was noted to drain from the catheter. NA-I commented that most of the urine was on the incontinent product and she stated her intentions to report the leaking of the catheter to the nurse. NA-I wiped the end of the catheter tubing with an alcohol wipe, then re-wiped and replaced the plug. NA-I discarded the gloves and washed her hands in the bathroom sink. NA-I was then interviewed regarding washing hands and changing gloves during the procedure. NA-I stated she thought she had used hand sanitizer before handling the door knob; however, she confirmed that she did not remember. NA-I verified she should have washed her hands prior to toileting R97, before donning gloves and after handling R97's soiled incontinent product. On 10/23/14, at 3:40 p.m. the RN-A confirmed the staff were to wash their hands prior to completing catheter related procedures, between changing of gloves and when going from dirty areas to clean areas. On 10/24/14, at 10:25 a.m. RN-A stated the facility did not routinely complete observational infection control audits of staff as part of the infection control program. The Handwashing/Hand Hygiene policy revised 4/12, indicated all personnel were to follow the hand washing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The policy directed employees to wash their hands before	F 441		

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F 441	Continued From page 37 and after direct contact with residents, before donning gloves, before and after handling invasive devices, after contact with resident body fluids/ excretions and after handling soiled or used linens, dressings, bedpans, catheters and urinals.	F 441	**F465** This facility does ensure that we provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.	
F 465 SS=E	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 failed to ensure walls, ceilings and closet doors were in good repair and/or clean in 19 of 40 resident rooms (109, 113, 116, 117, 121, 140, 144, 146, 147, 154, 160, 203, 204, 210, 223, 227, 235, 245 and 257) observed in the facility. Findings include: On 10/20/14 at 3:40 p.m., during a resident room observation in room 227, neither the hot or cold water in the bathroom worked. No water was able to be expelled from the faucet. On 10/23/14, at 11:00 a.m. during the environmental tour with the Director of Maintenance (DOM) and the Director of	F 465	1. <u>Corrective Action:</u> a. 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. <u>Corrective Action as it applies to other residents:</u> a. The facility will complete an audit of all resident rooms for repairs and will renovate as able. 3. <u>Reoccurrence will be prevented by:</u> a. The maintenance department will create an instruction sheet for all departments instructing how to use the TELS system for preventative maintenance. b. All departments will be educated on observing the environment for potential repairs and/or renovations that may need to be	

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F 465	Continued From page 38 Environmental Services (DES), the following concerns were identified: Room 109- The floor was observed with large black scratches in several areas. Chunks of plaster in areas measuring approximately 4 x 4 inches and 1 x 4 inches, where observed where a patch of bare drywall was exposed, to the right-side of the head of the bed. Room 113- The wall above the heater had a large gouge, with bare drywall exposed. Room 116- The bottom drawers of the two wooden dressers in the room were nicked, marred and splintered in multiple areas. Room 117- The front of the wooden dresser was marred, scratched and splintered in multiple areas. Room 121- The wooden dresser drawers were marred and scuffed. The bathroom door was marred and had deep gouges. The lens cover over the light in the bathroom (to the left-side of the bathroom mirror) was broken, with a large crack throughout. Room 140- The wall near the window, by the head of the bed, had food debris (dried spaghetti noodle and food drippings) adhered to it.	F 465	completed to ensure a sanitary and homelike environment. c. Weekly maintenance will tour each resident room in the facility and will document items that may need to be repaired and/or renovated to ensure a safe, functional, sanitary and comfortable environment for residents. 4. <u>The correction will be monitored by:</u> a. The process for compliance will be monitored by the Maintenance director, Environmental Services Supervisor and designees with oversight by Nursing Home Administrator. b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. <u>Date of Completion: 11/25/14</u>	

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F 465	Continued From page 39 Room 144- The floor had numerous black scuff marks next to the bed. Room 146- The grout on the bathroom floor was black with dirt. The radiator behind the foot of the bed-two was dusty, with dirt debris. The wall paper in the bathroom was stained in several areas and peeling. The left door handle on the metal closet door was missing. Room 147- A round vent to the left, upper wall of the bathroom was separated from the wall. A thick layer of dust was noted within the space between the vent and the wall. The dust was seeping from beneath the vent. Room 154- A large water stain was observed on the ceiling tile, above the toilet in the bathroom. Room 160- The left door handle on the metal closet door was missing. Room 203- The bottom of the bathroom door was chipped and rough. Room 204- The door jamb to the room was chipped, with rough edges. Room 210- The interior side of the bathroom door had multiple chipped areas, where paint was missing. The bathroom door jamb and door were chipped with rough edges. There was a large	F 465		

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F 465	Continued From page 40 chip out of the bottom dresser drawer, leaving splintered wood exposed. Room 223- The bathroom sink was dripping a steady stream of water and did not shut off. The bathroom wall vent was coated with a thick layer of dust. The metal closet door was missing the left handle. Room 227- The bathroom sink was not was not in proper working condition. The cold water was able to be turned on to the sink; however, no hot water could be expelled from the faucet. Room 235- The white, circular exhaust fan had a black substance on the wall surrounding the fan. Room 245- The vanity had multiple scratches on the front door and drawer. The sink counter was chipped along the front edge. Room 257- The white, circular exhaust fan was dusty and had a dried, liquid stain down the white cover and onto the wall. DOM and DES verified each of the above concerns identified throughout the environmental tour. On 10/23/14, at 11:59 a.m. DES stated she completed daily rounds and audited three rooms on each unit per day (15 rooms daily). If issues	F 465		

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F 465	Continued From page 41 were found, they were fixed. If there was a pattern of concerns, the staff were in-serviced (re-trained) and follow-up was completed within one week. DES stated the staff were to report any environmental issues to the nursing supervisor and the nursing supervisor was to report the issues to them for follow-through. DES confirmed the current reporting system was a problem and stated that reporting of maintenance and housekeeping concerns by floor staff was not consistently completed. DES added the staff needed more education. On 10/27/14, at 11:11 a.m. DES stated the facility had a form for staff to fill out if there were environmental concerns, but there were no formal policies and procedures in place.	F 465	**F520** This facility does have an active Quality Assessment and Assurance committee to ensure resident quality of life and quality of care concerns are identified, action plans developed, and monitoring provided to address the identified concerns. 1. Corrective Action: a. The facility appointed an Infection Preventist who will have oversight and responsibility of the Infection Control Program. This infection control program will include infection control audits of staff as part of the Infection Control Program. b. Employees who have any type of illness will be identified and the spell of illness will be tracked to determine if the illness requires quarantine from working with residents or if the illness requires reporting of any nature to local authorities. New employees will be trained during orientation regarding the infection control policies and procedures. Facility staff will be trained on infection control	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		

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F 520	Continued From page 42 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility lacked an active Quality Assessment and Assurance (QA&A) committee to ensure resident quality of life and quality of care concerns were identified, action plans developed, and monitoring provided to address the identified concerns. This had the potential to affect all 120 residents in the facility. Findings include: Refer to F441. The administrator and the director of nursing (DON), interviewed on 10/24/14, at 10:04 a.m., stated the facility QA&A committee met on a monthly basis. The DON stated there were no QA&A activities related to the quality of life/quality of care concerns identified during the survey. On 10/24/14, at 10:25 a.m. registered nurse (RN)-A stated the facility did not routinely complete observational infection control audits of staff as part of the infection control program.	F 520	practices to include Isolation policies and procedures. c. The Assistant director of Nurses have been trained on the above processes. d. Employees were educated on hand washing/hand hygiene. e. Employees were educated on self reporting illness. f. Nursing staff were educated on identifying and assessing staff with illness to determine if the staff needs to be quarantined. 2. <u>Corrective Action as it applies to other residents:</u> a. Residents who reside at Bayshore have the potential to be affected by this perceived practice violation as it relates to infection control. 3. <u>Reoccurrence will be prevented by:</u> a. Monitoring and identifying employee infections through an active surveillance program. b. Spot checking knowledge levels of staff members understanding of Standard Precautions. c. Monthly surveillance of facility infections will be reported during the monthly QAPI meeting and	

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F 520	Continued From page 43 The facility was unable to provide a policy and procedure on the QA&A committee.	F 520	appropriate actions taken concerning variances or issues found. 4. <u>Reoccurrence will be prevented by:</u> a. Employee illness will be tracked by the Human resource department and will be included in the QA committee meetings to track any trends of employee illness compared to resident illness b. Compliance will be monitored by the Director of Nurses and/or designee with oversight by the facility Administrator. Identified variances will be reported through the facility quality assurance and performance improvement team. d. <u>Date of Completion:</u> 11/25/14	

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

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K 000	INITIAL COMMENTS FIRE SAFETY 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. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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 not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-Tags) TO: Health Care Fire Inspections State Fire Marshal Division 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok PS 11-25-14 RECEIVED NOV 24 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION 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.	

DC: 12-3-14

Ltr: 10-24-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Katzenberger	Administrator	11/21/14

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
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2014**

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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K 000	Continued From page 1 By E-Mail to: Marian.whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 115 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	**K018** This facility does ensure that doors protecting corridor openings are constructed to resist the passage of smoke. 1. <u>Corrective Action:</u> a. The dutch door into an office on 1 SW had an astragal added to prevent the spreading of smoke. b. The housekeeping staff were educated on proper ways to hold a door open. c. The kitchen staff were educated on proper ways to hold a door open. d. Any resident in the facility with a seat belt has the potential to be affected by this perceived deficient practice. 2. <u>Corrective Action as it applies to other residents:</u> a. An audit of all dutch doors was completed to ensure that each had an astragal to prevent the spreading of smoke. b. The housekeeping staff were educated on proper ways to hold a door open. c. The kitchen staff were educated on proper ways to hold a door open.	
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2014**

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K 018 SS=E	Continued From page 2 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Juntunen, Jeff Based on observation the doors to the kitchen and house keeper room are being improper held open. The door to the nurses office on 1 SW has been made into a "Dutch" door and does not resist the passage of smoke This deficient practice could effect all building occupants in the event of a fire. Open doors would allow smoke to compromise the corridor exiting system. Findings Include: During the facility survey on 10-22-14 between 8:00AM-10:00AM, it was observed that the door	K 018	3. <u>Reoccurrence will be prevented by:</u> a. Maintenance and environmental services managers will complete random audits to ensure that doors are held open via appropriate means. 4. <u>The correction will be monitored by:</u> a. The process for compliance will be monitored by the maintenance and environmental services managers and designees with oversight by Nursing Home Administrator. b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. <u>Date of Completion: 11/25/14</u>	

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	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2014**

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K 018	Continued From page 3 to the first floor house keepers room and the door between the kitchen and dining room were being held open improperly. Doors that are required to be self closing shall comply with LSC(00) section 18-3.6.3. It was further observed that the door to the 1 SW Nursing office has been made into a "Dutch" style door. Both halves of the door shall be self closing and the meeting edge(s) shall resist the passage of smoke. This deficient practice was confirmed by Director of Plant Operations (GS) and the Administrator (SK) at the time of exit.	K 018	**K029** This facility does ensure that hazardous areas are protected by a fire rated hardware. 1. <u>Corrective Action:</u> a. The hardware on the door to the laundry room was replaced by fire rated hardware. b. Any resident in the facility with a seat belt has the potential to be affected by this perceived deficient practice.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect some patients.	K 029	2. <u>Corrective Action as it applies to other residents:</u> a. An audit of all doors in hazardous areas was completed to ensure that each had fire rated hardware in place. 3. <u>Reoccurrence will be prevented by:</u> a. Maintenance and environmental services managers will complete random audits to ensure that door hardware is not replaced by inappropriate hardware. 4. <u>The correction will be monitored by:</u>	

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	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2014**

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

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K 029	Continued From page 4 Findings include: During facility tour on 10-22-14 between 8:00-10:00AM, observation revealed that the fire rated door into the laundry room has had a residential grade latch installed. Fire rated doors shall be equipped with fire rated hardware. This deficient practice was verified by the Maintenance Director (GS) and the Administrator (SK) at the time of exit.	K 029	a. The process for compliance will be monitored by the maintenance and environmental services managers and designees with oversight by Nursing Home Administrator. b. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 11/25/14	

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6399

November 6, 2014

Ms. Shelley Katzenburger, Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5227025

Dear Ms. Katzenburger:

The above facility was surveyed on October 20, 2014 through October 24, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Patricia Halverson at the phone number listed above.

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

Please 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, 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

Enclosure(s)

00589 S5227025 GYIU11
BAYSHORE RESIDENCE & REHAB CTR
1601 ST LOUIS AVENUE
DULUTH, MN 55802
218-727-8651

Scanning Sheet

Fill in one:
Event #_____ Exit Date 10-24-14

Resident Name _____Resident #_____
or

Name of Facility Task_____

Surveyor Name PLN Federal Number 12835

Certification Survey X PCR survey_____ Other_____

If specific information from a complaint, make sub folder - Complaint H_____.

For Supervisors:

Circle appropriate scanning place:

Admin-- sub folder ~~h/th~~ h/th lis 2567 signed

Scan Docs-- sub folder

Send Papers to:

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00589	A. BUILDING: _____ B. WING _____	10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 20, 2014 through October 24, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	