DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GYQH Facility ID: 00589

	TO DE COMILI			EBUNITEDITO		1 acinty 12: 00009
MEDICARE/MEDICAID PROVIDER NO. (L1) 245227 2.STATE VENDOR OR MEDICAID NO.	3. NAME AND AD (L3) BAYSHORE (L4) 1601 ST LO	E RESIDENCE	E & REHA	B CTR	4. TYPE OF AC	2. Recertification
(L2) 1821433426	(L5) DULUTH, M			(L6) 55802	3. Termination 5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 07/01/2013	7. PROVIDER/SU 01 Hospital	UPPLIER CATEG	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visi 8. Full Survey	t 9. Other After Complaint
6. DATE OF SURVEY 01/28/2016 (L30 8. ACCREDITATION STATUS: (L10 0 Unaccredited 1 TJC 2 AOA 3 Other		06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR E	NDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 139 (L18 13.Total Certified Beds 139 (L17	Compliance 1. A B. Not in Comp	equirements e Based On: cceptable POC	am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code		of Services Limit al Director Room Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 S 139 (L37) (L38) (L3	NF ICF	and/or Applied V IID (L43)	waivers.	*Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12)	
16. STATE SURVEY AGENCY REMARKS (IF APP	LICABLE SHOW LTC CA	ANCELLATION I	DATE):			
See Attached Remarks						
17. SURVEYOR SIGNATURE	Date:			18. STATE SURVEY AGENCY		Date:
Kimberly Settergren, HFE NEII	0	2/25/2016	(L19)	Enforcement Sp	pecialist	02/29/2016 (L20)
PART II - TO	BE COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	Y
19. DETERMINATION OF ELIGIBILITY _X		IPLIANCE WITH HTS ACT:	H CIVIL	21. 1. Statement of Final2. Ownership/Control3. Both of the Above	ol Interest Disclosure	
22. ORIGINAL DATE 23. LTC AG	REEMENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION BEGIN. 01/22/1979	NING DATE	ENDING DA	ГЕ	VOLUNTARY 00-Merger, Closure	05-Fa	DLUNTARY il to Meet Health/Safety
(L24) (L41)		(L25)		02-Dissatisfaction W/ Reimburse		il to Meet Agreement
	NATIVE SANCTIONS ension of Admissions:			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTH	ER ovider Status Change
(L27) B. Resci	nd Suspension Date:	(L44) (L45)			00-Ac	tive
28. TERMINATION DATE:	29. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32. DETERMINATION	I OF APPROVAL	L DATE			
(L32)	01/11/2016		(L33)	DETERMINATION APPI	ROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GYOH Facility ID: 00589

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5227

On January 28, 2016, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiency issued pursuant to a PCR, completed on January 13, 2016. We presumed, based on your plan of correction, that the facility had corrected this deficiency as of January 22, 2016. Based on our visit, we determined that the facility had corrected the deficiency issued pursuant to our PCR, completed on January 28, 2016, effective January 22, 2016 As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective January 22, 2016. In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Per day civil money penalty, beginning October 22, 2015 and continuing through November 17, 2015, remain in effect. (42 CFR 488.430 through 488.444)
- Per day civil money penalty, beginning November 18, 2015 be discontinued, effective January 22, 2016. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016, be rescinded. (42 CFR 488.417 (b))

As we notified the facility in our letter of November 13, 2015 and CMS notified the facility in their letter of December 31, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 18, 2015. The CMS Region V Office will notify of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Effective January 22, 2016, the facility is certified for 139 skilled nursing facility beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245227

February 29, 2016

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

Dear Mr. Babbitt:

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 January 22, 2016 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

February 25, 2016

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

RE: Project Number S5227026

Dear Mr. Babbitt:

On November 13, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 18, 2015. (42 CFR 488.422)

On December 31, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of \$3,100.00 for twenty-seven (27) days beginning October 22, 2015 and continuing through November 17, 2015 for a total of \$83,700.00. (42 CFR 488.430 through 488.444)
- Per day civil money penalty of \$250.00 per day beginning November 18, 2015 until substantial compliance is achieved. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

This was based on the criteria that the facility not be given an opportunity to correct due to a "G" level deficiency cited at the previous abbreviated standard survey complete on February 20, 2015 and the

most recent abbreviated standard survey completed on October 23, 2015, an extended survey completed on November 18, 2015, where conditions in the facility at the time of the extended survey constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 13, 2016. The most serious deficiency at the time of the revisit was a widespread deficiency that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

As a result of the revisit findings, the Category 1 remedy of State monitoring remained in effect.

In addition, this Department recommended to the CMS Region V office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Per day civil money penalty, beginning October 22, 2015 and continuing through November 17, 2015, remain in effect. (42 CFR 488.430 through 488.444)
- Per day civil money penalty, beginning November 18, 2015 until substantial compliance is achieved, remain in effect. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016, remain in effect. (42 CFR 488.417 (b))

On January 28, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiency issued pursuant to a PCR, completed on January 13, 2016. We presumed, based on your plan of correction, that your facility had corrected this deficiency as of January 22, 2016. Based on our visit, we determined that your facility had corrected the deficiency issued pursuant to our PCR, completed on January 28, 2016, effective January 22, 2016

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective January 22, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Per day civil money penalty, beginning October 22, 2015 and continuing through November 17, 2015, remain in effect. (42 CFR 488.430 through 488.444)
- Per day civil money penalty, beginning November 18, 2015 be discontinued, effective January 22, 2016. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016, be rescinded. (42 CFR 488.417 (b))

As we notified you in our letter of November 13, 2015 and CMS notified you in their letter of December 31, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 18, 2015.

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

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 Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

FOLLOWU		EY C	OMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						
REVIEWED BY CMS RO [INITIALS] DATE					TITLE				DATE	
STATE AG		☑	REVIEWED BY (INITIALS) CC/KJ	DATE 02/25/2016	SIGNATUF	RE OF SURVEYOR	34089		01/28/2	016
LSC				LSC			LSC _			
Reg.#			Completed	Reg. #		Completed	Reg. #		Com	pleted
ID Prefix			Correction	ID Prefix		Correction	ID Prefix –		Corr	ection
LSC				LSC			LSC _			/
Reg. #			Completed	Reg. #		Completed	Reg.#		Com	pleted
ID Prefix			Correction	ID Prefix		Correction	ID Prefix –		Corr	ection
LSC				LSC			LSC _			
Reg.#			Completed	Reg. #		Completed	Reg.#		Com	pleted
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Corr	ection
LSC				LSC			LSC _			
Reg. # Completed Reg. #					Completed	Reg.#		Com	pleted	
ID Prefix Correction ID Prefix Correction						Correction	ID Prefix		Corr	ection
LSC			01/22/2016	LSC			LSC _			
Reg.#	483.65		Completed	Reg. #		Completed	Reg.#		Com	pleted
ID Prefix	F0441		Correction	ID Prefix		Correction	ID Prefix		Corr	ection
Y4			Y5	Y4		Y5	Y4		Y.	
program, corrected provision	to show the and the da number an y report for	ose d ate su ad the	by a qualified State surveyor leficiencies previously reported to corrective action was a decidentification prefix code p	orted on the CMS-25 ccomplished. Each	667, Staten deficiency	nent of Deficiencies and should be fully identifie	Plan of Correct dusing either	ction, that have the regulation or	r LSC	
BAYSHO	RE RESIDI	ENCI	E & REHAB CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802	:			
NAME OF	FACILITY		···			STREET ADDRESS, CIT	Y, STATE, ZIP C		l	
	ATION NUM							Y2	1/28/2016	Y3
PROVIDER	R / SUPPLIE	R/C			A1101	TILL VIOIT ILL			DATE OF REV	ISIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GYQH

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AG	ENCY		Facility ID: 00589
MEDICARE/MEDICAID PROVID (L1) 245227	PER NO.	3. NAME AND AI (L3) BAYSHORE			B CTR		4. TYPE OF AC	 · ·
2.STATE VENDOR OR MEDICAID	NO.	(L4) 1601 ST LO	UIS AVENUE				1. Initial 3. Termination	2. Recertification 4. CHOW
(L2) 1821433426		(L5) DULUTH, N	MN		(L6) 558	802	5. Validation 7. On-Site Visit	6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 07/01/2013	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 2	22 CLIA		After Complaint
	3/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	- 022.1		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID			FISCAL YEAR E	NDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	(210)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/31	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:		Ц		
From (a):		A. In Complia	ance With		And/Or Approved	Waivers Of T	The Following Requi	rements:
To (b):		Program Re	equirements		2. Technic	al Personnel	6. Scope o	of Services Limit
		Compliance	e Based On:		3. 24 Hour	r RN	7. Medica	al Director
10 T . 1 F . 11. D . 1	420 (110)	1. A	cceptable POC		4. 7-Day R	RN (Rural SN	F) 8. Patient	Room Size
12. Total Facility Beds	139 (L18)	***			5. Life Saf	fety Code	9. Beds/R	oom
13.Total Certified Beds	139 (L17)	X B. Not in Con Requirements	npliance with Pro and/or Applied	-	* Code: B*		(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY ME	ETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 18	61 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
See Attached Remarks	`			,				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVE	EY AGENCY	APPROVAL	Date:
Kimberly Settergren,	HFE NEII		01/25/2016	(L19)	Mark T	Neath	, Enforcement Sp	oecialist 02/25/2016 (L20
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	, ,	OFFICE OR S	INGLE ST	FATE AGENCY	,
19. DETERMINATION OF ELIGIBI	LITY		MPLIANCE WIT	H CIVIL			cial Solvency (HCFA 1 Interest Disclosure S	
X 1. Facility is Eligible to	Participate	KIGI	III3 ACI.			of the Above		stilit (HC1A-1313)
2. Facility is not Eligibl								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATIO	ON ACTION:		(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY	00	INVO	LUNTARY
01/22/1979					01-Merger, Closure		05-Fai	il to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction V	W/ Reimburse	ment 06-Fai	il to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	(220)		03-Risk of Involunta	ry Termination	n OTHE	ap.
23. ETC EXTENSION DATE.		n of Admissions:			04-Other Reason for	Withdrawal		ovider Status Change
	71. Buspension	or ramissions.	(L44)				00-Ac	· ·
(L27)	B. Rescind St	uspension Date:	,					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	L DATE				
	(I 22)	01/11/2016		(122)	DETERMINATION	TON ABER	20141	
	(L32)			(L33)	DETERMINAT	ION APPR	KUVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00589

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5227

On January 13, 2016, the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification Program and on December 23, 2015 the Department of Public Safety, completed a Post Certification Revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed October 23, 2015 and an extended survey, completed on November 18, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2015. Based on our visit, we have determined that the facility has not obtained substantial compliance with the deficiency issued pursuant to our extended survey, completed on October 23, 2015. The deficiency not corrected is as follows:

- F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

The deficiency in the facility was found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). As a result of the revisit findings, the Category 1 remedy of state monitoring remains in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Per day civil money penalty for twenty-seven days beginning October 22, 2015 and continuing through November 17, 2015
- Per day civil money penalty, beginning November 18, 2015 until substantial compliance is achieved, remain in effect.
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 23, 2016, remain in effect.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015.

Refer to the CMS 2567b forms and CMS 2567 along with the facilitys plan of correction for the results of this visit. PCR to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5484

January 19, 2016

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

RE: Project Number H5227053, H5227054, S5227026

Dear Mr. Babbitt:

On November 13, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 18, 2015. (42 CFR 488.422)

On December 31, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal civil money penalty of \$3,100.00 per day for the twenty-seven (27) days beginning October 22, 2015 and continuing through November 17, 2015 for a total of \$83,700.00.
- Federal civil money penalty of \$250.00 per day beginning November 18, 2015 until substantial compliance is achieved.
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on October 23, 2015 and an extended survey completed on November 18, 2015. At the time of the November 18, 2015 extended survey conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health and safety. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On January 13, 2016, the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification Program completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed October 23, 2015 and an extended survey, completed on

November 18, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2015. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiency issued pursuant to our extended survey, completed on October 23, 2015. The deficiency not corrected is as follows:

F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiency in your facility were found 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.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 31, 2015:

- Federal civil money penalty of \$3,100.00 per day for the twenty-seven (27) days beginning October 22, 2015 and continuing through November 17, 2015 for a total of \$83,700.00, remain in effect.
- Federal civil money penalty of \$250.00 per day beginning November 18, 2015 until substantial compliance is achieved, remain in effect.
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 23, 2016, remain in effect. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

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.

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

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 alleviatedin 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.

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

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 23, 2016 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: licensing and Certification File

RECEIVED

PRINTED: 01/19/2016 FORMAPPROVED OMB NO. 0938-0391

A WINDS AND THE PROPERTY.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPL	E CONSTRUCTION JAN 2 2 2016		e survey Pleted				
		245227	B. WING		MN Dept of Health Duluth		R 13/2016				
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	1	s	TREET ADDRESS, CITY, STATE, ZIP CODE		.10/2010				
DAVOUO		THE STD		1	601 ST LOUIS AVENUE						
BAYSHO	RE RESIDENCE & RE	HABCIR		ם	OULUTH, MN 55802						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE				
					1. Residents # 166 and # 73 we	re not					
{F 000}	INITIAL COMMENT	TS .	{F 0	00}	affected by the alleged defic	ent					
					practice.						
		was conducted by surveyors			2. All residents may have been		•				
		on 1/11/16, 1/12/16, and ne compliance with Federal	را		affected by the alleged defici	ent					
:		during a recertification survey	′		practice. No residents have						
	exited on 11/18/15.	During this visit the following			developed any infection requ	iiring					
	regulations were de	termined to be not corrected.			isolation.	J					
					3. Staff were re educated on In	fection					
	Because you are er	nrolled in ePOĊ, your			Control Isolation procedures						
		uired at the bottom of the first			- Standard precautions						
		567 form. Your electronic			- Droplet precaution proce	dures					
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	vermodition of comp				with an emphasis on contact						
		acceptable electronic POC, an			precautions related to C-Diff;						
		r facility will be conducted to			Specifically;						
		ntial compliance with the n attained in accordance with			- Staff will donne gown an	Ч	,				
	your verification.	,, 414, 134, 114, 114, 114, 114, 114, 11			gloves prior to entering t						
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SS≒F	SPREAD, LINENS				the resident in the room	I					
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		ogram designed to provide a			gloves then go and wash	I					
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		tablish an Infection Control			be used to wipe down ar	- 1					
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		ER/SUPPLIER REPRESENTATIVE'S SIGNA			TITLE		(X6) DATE				
	IN CLARK	To Allow	N157	12 4	1-22-20	10					

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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NAME OF PROVIDER OR SUPPLIER		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(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 new "orange wipes" that will be used to wipe down any equipment such as a mechanical lifts, that leave the room. - The new "orange wipes" that will be used to wipe down any equipment such as a mechanical lifts, that leave the room.		of disease and infec	ction.					
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(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 equipment such as a mechanical lifts, that leave the room. The new "orange wipes" are a							1	
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 mechanical lifts, that leave the room. - The new "orange wipes" are a						-	ıy	
(2) Decides what procedures, such as isolation, should be applied to an individual resident and (3) Maintains a record of incidents and corrective room . The new "orange wipes " are a			ntrois, and prevents infections			1	vo tha	
should be applied to an individual resident and (3) Maintains a record of incidents and corrective - The new "orange wipes " are a			ocedures, such as isolation,			·	ive the	
(b) Walltaine a reserve of melastic and serve		should be applied to	an individual resident and				, 0,00	
actions related to infections. new product called PDI Sani		(3) Maintains a record of incidents and corrective					f	
ARORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						•		

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

Facility ID: 00589

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

AND PLAN OF CORRECTION (X:	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		e survey Pleted
	245227	B. WING			l .	R 13/2016
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHA (X4) ID SUMMARY STATEM	AB CTR MENT OF DEFICIENCIES	ID	1601	ET ADDRESS, CITY, STATE, ZIP CODE ST LOUIS AVENUE UTH, MN 55802 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	PREFI) TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
isolate the resident. (2) The facility must procommunicable disease from direct contact will trans (3) The facility must rehands after each direct hand washing is indicated professional practice. (c) Linens Personnel must handle transport linens so as transport linens so as transport linens are infection. This REQUIREMENT by: Based on observation review, the facility failed control isolation precauting lemented for 2 of 2 diagnosed with clostrid infection. This had the residents in the facility. Findings include: The Center for Disease for health care facilities when caring for resider	of Infection Control Program dent needs isolation to infection, the facility must cohibit employees with a e or infected skin lesions h residents or their food, if smit the disease. equire staff to wash their t resident contact for which ated by accepted e, store, process and to prevent the spread of is not met as evidenced , interview and document d to ensure infection ution practices were residents (R166, R73) lium-difficile (C-Diff) potential to affect all 108	{F 44	11}	The new "orange wipes a r product called PDI Sani-Wi bleach germicidal wipe with bleach additive. Specifically developed to kill the C-Different developed to kill the C-Differe	pe ch a y f spore. e csident eaning /e f room; or ooms. PE d high ed tion sing ch	

	NT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '		CONSTRUCTION	COMPLETED		
		245227	B. WING			l	⋜ 13/2016	
	PROVIDER OR SUPPLIER			160	REET ADDRESS, CITY, STATE, ZIP CODE 11 ST LOUIS AVENUE ILUTH, MN 55802			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 441}	inflammation, know diarrhea, fever, and patients with C-Diff gowns when treating during short visits. C-Diff, and althought still may not be simportance of glov patients' rooms and room surfaces thou treating a patient with discharge or transformeded with use of EPA-approved, sport R166's Admission that included osteosepsis. R166's addressepsis. R166's addressepsi	e large intestine, or colon. This wn as colitis, can cause d abdominal cramps): Isolate f immediately. Wear gloves and ng patients with C-Diff, even Hand sanitizer does not kill gh hand washing works better, ufficient alone, thus the res. Use gowns when entering d during patient care. Clean roughly on a daily basis while with C-Diff and upon patient fer. Supplement cleaning as f bleach or another ore-killing disinfectant. Record identified diagnoses omyelitis, osteoarthritis and mission Minimum Data Set 2/15, indicated R166 was equired extensive assistance et use and had a colostomy. on 1/7/16, identified the in R166's stool. Dip.m. the director of nursing 6 was in isolation precautions ection. Dis room was observed. There art outside of the room that gloves and purple-top PDI icidal wipes not effective res). A sign on R166's door e nurse before entering.	{F 4	41}	Dispose of gloves and gow wash hands with soap and before leaving the room.			
	and nursing assist	ant (NA)-C was observed to . NA-C knocked on the door,						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		(X3) DATE SURVEY COMPLETED		
				_		R	
		245227	B. WING_			01/	13/2016
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	HAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	on her hands. NA-C spoke with him, use hands and left the rewalked to R166's rohands, placed the cused an alcohol-bast the coffee cup and ea.m. NA-C used an hands and left R166. On 1/12/16, at 9:35 and stated she was donne gloves to go the gloves and wash room. NA-C stated sto wear a gown unle R166. NA-C verified gel for hand hygiene R73's Admission Reincluded hypertensic anemia. The quarter indicated R73 was observed in R73's stool On 1/12/16, at 12:51 (RN)-B was observed front of R73's room directed please see R73's door.	and used an alcohol-based gel is shut off R166's call light, and an alcohol-based gel on her com. At 9:23 a.m. NA-C om with a cup of coffee in her offee on the isolation cart, sed gel on her hands, grabbed entered R166's room. At 9:24 alcohol-based gel on her s's room. a.m. NA-C was interviewed, taught to wash her hands and into R166's room and remove in her hands when she left the she was told she did not need ess she was doing cares on she used an alcohol-based of the properties of two staff for transfers and continent of bowel. Laboratory dentified the presence of	{F 44	111}	4. Observation audits to monitor are following isolation procedu be conducted on all three shifts (4) audits per week on the day and one (1) audit per week on evening (2-10:30) shift and one audit per week on the night (10 shift. The results of the observate audits will be presented to the monthly QAPI committee for the months to monitor the staff is following the Infection control-Isolation guidelines. After three months, the QAPI committee we recommended. 5. The Director of Nursing, the Infection of Nurse and the Houseke Supervisor will be responsible for compliance with oversight from Administrator. Completion date of January 22, 20	res will s: four shift; the (1) 0-6:30) ation aree e fill ang is ection eping or a the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
						l .	٦
		245227	B. WING			01/	13/2016
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PROVIDER OR SUPPLIER RE RESIDENCE & RE	HAB CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	sani-wipes to wipe of the hoyer lift into R7 came out of R73's r down with PDI purp On 1/13/15, at 9:08	and used PDI purple top off the hoyer lift. NA-P brought 73's room. At 8:04 a.m. NA-P room and wiped the hoyer lift le top sani-wipes. a.m. trained medication	{F 4	41}			
	facility did not have as hoyer lifts, stetho or thermometers) fo isolation. TMA-F sta	vas interviewed and stated the dedicated equipment (such escopes, blood pressure cuffs or residents who were in ated any shared equipment y nursing staff with PDI purple					
	and stated the facili equipment for those precautions. RN-B purple top sani-wipe equipment, howeve purple top sani-wipe						
	interviewed and sta to follow isolation pr DON confirmed tha	5 a.m. the DON was ted she would expect all staff recautions. At 11:40 a.m. the t PDI purple top sani-wipes nd did not kill C-Diff spores.					
	was interviewed an	4 a.m. housekeeper (H)-B d stated he used bleach wipes olation precautions for C-Diff					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245227						
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	HAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		13/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE OPRIATE	(X5) COMPLETION DATE		
{F 441}	and did this daily. He would wear whe depended on wheth the room. H-B state in the room, he would but if the resident wonly wear gloves. The undated facility Clostridium Difficile must be donned an providers before en upon entering the rowith the resident or environment, perforand water upon exit possible, non-critical	a-B stated the protective gear in cleaning a room with C-Differ or not the resident was in ad if the resident was present ald donne a gown and gloves, as not in the room he would a policy and procedure on directed the following: gloves d worn by all healthcare tering the room, donne gown from when anticipating contact the resident's immediate im hand hygiene with soap ting the resident's room, when all care equipment should be sident and cleanse reusable	{F 44	4.Audits will be conducted four (4) per week times four (4) weeks, the (2) times per week times (8) week monitor staff are following the Interval Control guidelines for Isolation promoted to the audits will be presented to the monthly QAPI committee for threeto monitor the Facility/staff is folthe Infection Control—Isolation grafter three months, the QAPI comwill recommended. 1. The Director of Nursing, the Infection Control Nurse, and the Housekeeping Supervisor will be responsible for compliance with the from the Administrator. Completion date of January 22, 2	en two ks to rection recedures. e e months rowing ridelines. ring is ne versight			

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 245227	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/13/2016
Nam	e of Facility		Street Address, City, State, Zip Code	
BA	YSHORE RESIDENCE & REHAB C	ГВ	1601 ST LOUIS AVENUE	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5) Date	(Y4)	Item	((Y5) I	Date
			Correction				Correction					Correction
ID Prefix	F0161		Completed 12/31/2015	ID Prefix	F01	64	Completed 12/31/2015		ID Prefix	F0166		Completed 12/31/2015
	483.10(c)(7)					0(e), 483.75(I)(4)	- - -		Reg. # LSC	483.10(f)(2)		-
			Correction				Correction					Correction
ID Prefix	F0225		Completed 12/31/2015	ID Prefix	F02	26	Completed 12/31/2015		ID Prefix	F0241		Completed 12/31/2015
Reg. #	483.13(c)(1)(i	i)-(iii), (c)(2	·) -	Reg. #	483.1		_		Reg. #	483.15(a)		
ID Prefix			Correction Completed 12/31/2015	ID Prefix			Correction Completed 12/31/2015			F0282		Correction Completed 12/31/2015
Reg. # LSC	483.15(b)			Reg. # LSC	483.2	0(d)(3), 483.10(k)	(2)			483.20(k)(3)(ii		- - -
		1	Correction				Correction					Correction
ID Prefix	F0285		Completed 12/31/2015	ID Prefix	F03	09	Completed 12/31/2015		ID Prefix	F0314		Completed 12/31/2015
	483.20(m), 48			Reg. # LSC		5	- -			483.25(c)		 _
ID Prefix	F0323		Correction Completed 12/31/2015	ID Prefix	F03:	25	Correction Completed 12/31/2015		ID Prefix	F0333		Correction Completed 12/31/2015
	483.25(h)			Reg. # LSC		5(i)	- - -			483.25(m)(2)		
Reviewed I	Ву	Reviewed	Ву	Date:		Signature of Su	rveyor:	•			Date:	
State Agen	су	CC/mn	n	01/19/20	016		29433				01/13	3/2016
Reviewed I	Ву	Reviewed	Ву	Date:		Signature of Su	rveyor:				Date:	

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1)	Provider / Supplier / CLIA / Identification Number 245227	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/13/2016		
Name of Facility			Street Address, City, State, Zip Code			
BAYSHORE RESIDENCE & REHAB CTR			1601 ST LOUIS AVENUE DULUTH, MN 55802			

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(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y 5)	Date
ID Prefix	F0356 483.30(e)		Correction Completed 12/31/2015	ID Prefix	F0428 483.60(c)		Correction Completed 12/31/2015		ID Prefix	F0431 483.60(b), (d),	(a)	Correction Completed 12/31/2015
	403.30(e)		<u> </u>		403.00(0)					403.00(D), (d),		<u> </u>
ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 12/31/2015	ID Prefix			Correction Completed 12/31/2015			F0495 483.75(e)(4)		Correction Completed 12/31/2015
	F0496 483.75(e)(5)-		Correction Completed 12/31/2015		F0498 483.75(f)		Correction Completed 12/31/2015		ID Prefix Reg. #			Correction Completed 12/31/2015
	F0502 483.75(j)(1)		Correction Completed 12/31/2015	ID Prefix Reg. # LSC	F0508 483.75(k)(1)		Correction Completed 12/31/2015		ID Prefix Reg. # LSC	F0514 483.75(I)(1)		Correction Completed 12/31/2015
ID Prefix Reg. # LSC	F0519 483.75(n)		Correction Completed 12/31/2015	_								
Reviewed I		Reviewed	-	Date: 01/19/20	Signature	of Sui	veyor: 29433				Date: 01/13	3/2016
Reviewed I	Ву	Reviewed	I Ву	Date:	Signature	of Sui	veyor:				Date:	
Followup to Survey Completed on: 11/18/2015				Check for any Uncorrected					Summary of the Facility?	YES	NO	

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number 245227	(Y2) Multiple Con A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 12/23/2015			
Name of Facility			Street Address, City, State, Zip Code				
BAYSHORE RESIDENCE & REHAB CT	R		1601 ST LOUIS AVENUE				
		DIJITH MN 55802					

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) [Date	(Y4)	Item		(Y5)	Date
		Correction			Co	rrection					Correction
ID Prefix		Completed 12/01/2015	ID Prefix			mpleted /01/2015		ID Prefix			Completed 12/01/2015
Reg. #	NFPA 101		Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0029		LSC	K0067				LSC	K0147		_
		Correction			Co	orrection					Correction
ID Dog for		Completed	ID Doctor		Co	mpleted		ID Destin			Completed
	NEDA 101	12/01/2015		NEDA 101	12/	/01/2015					
•	NFPA 101 K0154			NFPA 101 K0155				Reg. # LSC			
		Correction				rrection					Correction
ID Prefix		Completed	ID Prefix	-	Co	mpleted		ID Prefix			Completed
Reg. #			Reg. #					Rea.#			
LSC								LSC			_
		Correction			Co	orrection					Correction
		Completed				mpleted					Completed
ID Prefix			ID Prefix					ID Prefix			<u> </u>
Reg. # LSC			Reg. # LSC					Reg. #			<u>—</u>
			130					130			
		Correction			Co	rrection					Correction
ID Prefix		Completed	ID Prefix			mpleted		ID Prefix			Completed
Reg. #			Reg. #					Reg. #			_
								LSC			
Reviewed I	By Rev	viewed By	Date:	Signature	e of Survey	yor:				Date:	
State Agency T		`L/mm	01/19/20	016		27200				12/2	3/2015
Reviewed By Re		viewed By	Date:	Signature	e of Survey	yor:				Date:	
Followup to Survey Completed on: 11/12/2015				Check for an Uncorrecte	y Uncorrected Deficier	cted Defic ncies (CM	ienci S-256	es. Was a 67) Sent to	Summary o	of ? YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GYQH

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	THE STAT	ATE SURVEY AGENCY Facility ID: 00589								
1. MEDICARE/MEDICAID PROVIDER N (L1) 245227 2.STATE VENDOR OR MEDICAID NO. (L2) 1821433426	3. NAME AND ADDRESS OF FACILITY (L3) BAYSHORE RESIDENCE & REHAB CT (L4) 1601 ST LOUIS AVENUE (L5) DULUTH, MN				55802	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	N: 2 (L8) 2. Recertification 4. CHOW 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OW (L9) 07/01/2013	NERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			02 (L7)) 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 11/18 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN	IG DATE: (L35)		
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds	139 (L18) 139 (L17)	X B. Not in Com	equirements	n	2. Tech 3. 24 H 4. 7-Di	hnical Personnel	Following Requirements:	ector		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 139	19 SNF	ICF	IID		15. FACILITY M 1861 (e) (1) or		(L15)			
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMARKS See Attached Remarks	KS (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):							
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY API	PROVAL	Date:		
Teresa Ament, HFE	NEII		12/31/2015	(L19)	Mark	Meath	, Enforcement Spe	01/08/2016 (L20)		
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY	(122)		
DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C	CIVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HC	FA-1513)		
22. ORIGINAL DATE OF PARTICIPATION 01/22/1979	23. LTC AGREEM BEGINNING		24. LTC AGREEMI ENDING DAT		26. TERMINAT VOLUNTARY 01-Merger, Closu 02. Discretisfaction	00	05-Fail to	Meet Health/Safety		
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L25)			intary Termination	OTHER	Meet Agreement er Status Change		
28. TERMINATION DATE:	29	. INTERMEDIARY/C	(L45) ARRIER NO.		30. REMARKS					
		03001								
	(L28)			(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	TE	Posted 0	1/11/2016 Co.				
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL			

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00589

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5227

On November 13, 2015, we notified the facility of the following enforcement remedies:

- -State Monitoring effective November 18, 2015.
- Civil money penalty for deficiency cited at F333 (S/S=G), effective October 23, 2015.

This was based on the criteria that the facility not be given an opportunity to correct before remedies are imposed as a result of a level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy (level G)) cited at the previous intervening abbreviated standard survey completed on February 20, 2015 as well as the current abbreviated standard survey completed on October 23, 2015 (Investigation of complaint H5227053).

On November 18, 2015 an extended survey was completed at this facility, Conditions in the facility constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health safety. The survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J, whereby corrections were required. In addition, at the time of the November 18, 2015 extended survey, an investigation of complaint number H5227054 was conducted and found to be unsubstantiated.

As a result of the November 18, 2015 standard survey, the Category 1 remedy of State monitoring would remain in effect.

In addition, we recommended the following action to the CMS Region V Office related to the enforcement remedy detailed in our letter of Novmeber 13, 2015:

- Civil money penalty for deficiency cited at F333 (S/S=G), effective October 23, 2015, remain in. effect.

Based on the findings of the extended survey completed November 18, 2015, we are recommending the following additional remedies to the CMS Region V Office:

- Civil money penalty for deficiency cited at F309 (S/S=G), effective November 18, 2015.
- Civil money penalty for deficiency cited at F323 (S/S=J, reduced to a S/S=G when the IJ was removed), effective November 18, 2015. (42
- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 23, 2016.

Futher, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015.

Refer to the CMS 2567 forms along with the facilitys plan of correction. Post Certification Revisit (PCR) to follow.



Sent via United Parcel Service (UPS) Priority Ovenight on December 9, 2015

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

RE: Project Number H5227053, SS5227026, H5227054

Dear Mr. Babbitt:

On November 13, 2015, we informed you that the following enforcement remedy was being imposed:

State Monitoring effective November 18, 2015. (42 CFR 488.422)

On November 13, 2015, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Civil money penalty for deficiency cited at F333 (S/S=G), effective October 23, 2015. (42 CFR 488.430 through 488.444).

This was based on the criteria that the facility not be given an opportunity to correct before remedies are imposed as a result of a level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy (level G)) cited at the previous intervening abbreviated standard survey completed on February 20, 2015 as well as the current abbreviated standard survey completed on October 23, 2015.

On November 18, 2015, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 18, 2015 extended survey the Minnesota Department of Health completed an investigation of complaint number H5227054 that was found to be unsubstantiated.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J, whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Bayshore Residence & Rehabilitation Center December 9, 2015 Page 2

As a result the the facility continues to not be in substantial compliance, the Category 1 remedy of state monitoring will remain in effect.

In addition, we are recommending the following action to the CMS Region V Office related to the remedy detailed in our letter of November 13, 2015:

• Civil money penalty for deficiency cited at F333 (S/S=G), effective October 23, 2015, remain in effect. (42 CFR 488.430 through 488.444).

Based on the findings of the extended survey completed November 18, 2015, we are recommending the following additional remedies to the CMS Region V Office:

- Civil money penalty for deficiency cited at F309 (S/S=G), effective November 18, 2015. (42 CFR 488.430 through 488.444).
- Civil money penalty for deficiency cited at F323 (S/S=J, reduced to a S/S=G when the IJ was removed), effective November 18, 2015. (42 CFR 488.430 through 488.444).
- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

Futher, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Bayshore Residence & Rehabilitation Center December 9, 2015 Page 3

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on November 18, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Chris Campbell, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

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

Bayshore Residence & Rehabilitation Center December 9, 2015 Page 4

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayshore Residence & Rehab Ctr is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Bayshore Residence & Rehabilitation Center December 9, 2015 Page 5

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

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 aresustained. 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;

Bayshore Residence & Rehabilitation Center December 9, 2015
Page 6

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Bayshore Residence & Rehabilitation Center December 9, 2015 Page 7

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 23, 2016 (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 23, 2016 (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 Health Regulation Division 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.

Bayshore Residence & Rehabilitation Center December 9, 2015 Page 8

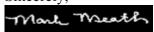
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 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 Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

MAKE OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR SAMMER'S STATEMENT OF DEPOSITIONS SAMMER'S STATEMENT OF DEPOSITIONS FROM INITIAL COMMENTS The facility plan of correction (POC) will serve as you 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 with the regulations has been attained in accordance with your verification. An investigation of complaint was unsubstantiated. An extended survey was conducted to 11/12/2015, an extended survey was initiated due to an immediate Jeopardy was removed on 11/18/2015. The survey resulted in an immediate Jeopardy was removed on 11/18/2015. The survey resulted in an immediate Jeopardy was removed on 11/18/2015. The immediate jacpardy was removed on 11/18/15, at 10:30 a.m. after it was verified that the facility effectively implement interventions in order to minimize the risk of falls with serious injury or death for R81 who had frequent falls. The immediate jacpardy was removed on 11/18/15, at 10:30 a.m. after it was verified that the facility effectively implemented a removal plan. Fig. 14 483,10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS ADMANDAL PERSONAL FUNDS ADMAND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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PRINTED: 12/09/2015 FORM APPROVED OMB NO 0938-0391

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FÖRM CMS-2567(02-88) Previous Versions Obsolete

Event ID: GYQH91

Facility IO: 00589

If confinuation sheet Page 1 of 116

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 65802	,		
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The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personel funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the surety bond was sufficient to cover the total amount in the resident fund accounts. This had the potential to impact 83 previous and current residents who had money in the account. Findings include: A review of the facility's surety bond (insurance that protects the resident personal funds in trust fund account held by the facility), revealed the amount of the surety bond was less than the total of the resident funds held by the facility. The strety bond dated 10/24/13, Indicated the resident personal funds were protected up to a total of \$39,000. The facility trust fund balance report dated 11/11/16, indicated 139 residents who now reside in the facility thad an open trust fund account for a total of \$38,829.27. 83 of 159 current residents had money in the trust fund. The surety bond was not sufficient to secure the total resident monies held by the facility. During an interview on 11/17/16, at 3:15 p.m. the administrator verified the surety bond was not	surety ch covers fund. The week I balance, will monitor each week the Surety und balance, distrator action to reported to or three QAPI condation as for that the ident trust		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUSLDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING_			11/	18/2016
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS 1801 ST LOUIS A DULUTH, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL ESC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACI	COVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIAT DEFICENCY)		(X5) GDMFLSTI(XN DATE
	sufficient to cover the The facility policy and Trust Account dated bond would be mainte fund account and would 483.10(e), 483.75(f)(4 PRIVACY/CONFIDED The resident has the confidentiality of his of records. Personal privacy inclumedical treatment, we communications, per- meetings of family and does not require the ti- room for each resident Except as provided in section, the resident release of personal a individual outside the The resident's right to and clinical records di resident is transferred institution; or record in The facility must keep contained in the resid the form or storage in release is required by	resident fund balance. I procedure for Resident I/2015, indicated a surety ained on the resident trust Uld be renewed annually I) PERSONAL NTIALITY OF RECORDS right to personal privacy and or her personal and clinical udes accommodations, ritten and telephone sonal care, visits, and of resident groups, but this facility to provide a private int. I paragraph (e)(3) of this may approve or refuse the ind clinical records to any facility. I refuse release of personal des not apply when the I to another health care release is required by law. I confidential all information lent's records, regardless of methods, except when I transfer to another I law; third party payment	F	1. F ti d 2. A	Resident #46 was not affecte the alleged deficient practice documented by Social Service. All residents have the potent peing affected by the alleged deficient practice.	as ces. ial for	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA INDEPLAN OF CORRECTION IDENTIFICATION NUMBER:		1''	MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11.	/18/2015
BAYSHOR (X4) ID		ATEMENT OF DEFICIENCIES	ID		OF ST LOUIS AVENUE ULUTH, MIN 65802 PROVIDER'S PLAN OF GORRECTION		(35)
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR I Continued From page This REQUIREMENT by: Based on observation review, the facility failt privacy during a pain a pass for 1 of 1 resider privacy. Findings include: R46's Admission Recoincluded chronic kildned diabetes, and chronic quarterly Minimum Da indicated R46 was considered at 11/13/15 oxycodone every four On 11/12/15, at 8:55 a aide (TMA)-B was obsected in the hallway. W TMA-B called loudly, " who was in his room w be heard by any reside in the hallway. When asking about R46's pa TMA-B replied, "I guest explain R46 is hard of In an interview on 11/1 registered nurse (RN)- expected ficensed stat privacy. RN-A continu- nurse would go into a	ATEMENT OF DEFICIENCIES WINDST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 3 is not met as evidenced In, interview and document and to maintain resident assessment/medication als (R46) reviewed for ord identified diagnoses that ay disease stage 4, type 2 paln due to trauma. The ala Set (MDS) dated 9/4/15, gnitively intact and received ations. The physician's a, directed R46 to receive hours, as needed, for paln. a.m., trained medication between at the medication hile standing at the cart, What's your pain?" to R46, with the TV on. This could ent, staff or visitor who was asked if this method of in maintained privacy, as not", and continued to hearing so she had to yell. 13/15, at 9:52 a.m.,	PREFIX TAG			ent's ed ed s to sting a ve staff d to ew. f to good	(X5) COMPLETION DATE
	stated if the resident w even more reason for resident's side.	ere hard of hearing, that is the nurse to be at the				:	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE GOMP	SURVEY
		245227	a. WING_			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		160	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PRESIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XB) COMPLETION DATE
F 166	5/11, directed staff wiregarding their condit addition, the facility's policy, dated 10/14, divoice when discussing information or move to 483.10(f)(2) RIGHT TRESOLVE GRIEVAN A resident has the rigit facility to resolve griethave, including those of other residents. This REQUIREMENT by: Based on interview a facility falled to ensuring rievances, and feed residents (R42), reviewalled quadriplegial depression, and anxiom mum Data Set (Not indicated intact cogniting and personal hygiene 10/4/13, Indicated R4 injury/abuse due to mot become a targereceive injuries from a serial serial procession and a stargereceive injuries from a serial procession and appropriate transfers.	Privacy undated, reviewed in II speak with residents ions in a private area. In HIPAA and Confidentiality irected staff to lower their g protected health of a private area. O PROMPT EFFORTS TO CES In the prompt efforts by the vances the resident may with respect to the behavior with respect to the behavior is not met as evidenced and document review, the eleprompt resolution of back to residents, for 1 of 1 ewed for grievances. In Indicated diagnoses that the type 2 diabetes, ety. R42's quarterly IDS) dated 9/25/15, tion. The MDS also dextensive assistance for y, dressing, eating, toileting at R42's care plan dated 2 was at risk for nobility deficits, with the goal et of abuse, retaliation or another. Interventions or psychological, emotional	F 1		1. Resident #42 stated to the Director Social Services that he was not affect the alleged deficient practice. Weekly meetings between Social Services and resident # 42 have been initiated. 2. All residents have the potential to laffected by the alleged deficient practice. The Administrator and Director of Services reviewed and revised the Poregarding Resident Concerns. The Porevised to include documentation that resident has been informed of the investigation and resolution of the co. The Administrator and Director of Services will review all resolutions.	of ed by d d Social licy olicy is t the	

Facility ID; 00589

245227 B. WING	8/2015
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	
(X4LID SUMMARY STATEMENT OF DESIGNATION ID PROVIDENCE ALABOR COORDESTION	
BOTTIN (FLOUR PROPERTY AND THE PROPERTY	(X5) COMPLETION DATE
In an interview on 11/9/15, at 6:03 p.m., R42 stated he has made multiple complaints about a specific nursing assistant (NA) being very loud at night. R42 said every night this NA works, he gets woken up. R42 stated at the supper meal he just left, line NA didn't ask him a question directly, but asked another staff person to ask R42 a question. R42 stated this "attitude" all started when he made a complaint. In the Interview, R42 stated the facility social worker has said they're doing something about noise at night, but nothing has changed. R42 has requested that a NA not care for him, but has been told that the NA can't be taken off the unit and that if he won't have the NA in his room, then his cares won't get done. During the interview, R42 said he was done complaining because all that happens is more attitude from nursing assistants. R42 said that when he recently complained, a nurse wrote up a behavior incident on him and then the nurse practitioner asked if he wanted to re-start antidepressant medication. R42 stated he is worried that if he says anything, he'll have to go back on his antidepressant. In an interview on 11/13/15, at 11:07 a.m., the social service director (SSD) stated when a complaint is filed, they notify the Director of Nursing and the administrator; they report to the state agency if necessary, and make sure the resident is safe. Ultimately, the written completes the follow-up and coordinates work with the appropriate department. The SSD stated residents can were taking and staff can	

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/SUP ND PLAN OF CORRECTION (DENTIFICATION NUMBER:		A. BUILO		(X3) DATE SURVEY COMPLETED			
		245227	B. WING			11/18/2015		
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	•	160	EET ADDRESS, CITY, STATE, ZIP CODE 1 ST LOUIS AVENUE LUTH, MIN 65802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFU TAG	ς	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMFLETION DATE	
F 166	department tracks col- quality assurance (Q/ residents are care plate accusations about state investigates. The faciliafter a pattern is iden. During the 11/13/15, is SSD stated that R42 staff person work with maybe in June. The Sthese requests and the NA does not normally people are needed the unless R42 "says no." In an interview on 11/2 stated he did talk to the unit's nurse manable his concerns of loud if they did tell him they has gotten no other in of the grievance. In an interview on 11/2 stated the facility has typically begins with off the grievance. In an interview on 11/2 stated the facility has typically begins with off the grievance. SSD stated she had in 10/22/15, by R42 of in she talked to the night SSD stated the night.	ce form. The social services implaints and reports to A). The SSD stated some inned for making false off, but the facility still lity will care plan this only tified with a resident. at 11:07 a.m., interview, the did request to not have a him, a long time ago, as D stated R42 will make the change his mind. The work with R42, but If two is NA will come to assist, and facility social worker and ager more than once about NA's at night. R42 stated are "working on it" but he atomation about the status of 18/15, at 8:03 a.m., SSD a grievance process that completion of a complaint report orally, but they prefer ecause it is better for SD stated social services aints and kept a log of received one complaint on toise at night. SSD stated at nurse about the complaint.	F	166				

Pacility ID: 00589

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING_			11/	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA SUMMARY STA			16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFIÇIEND)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(XS) COMPLETION DATE
F 225 SS=D	it is their day, but it is stated when she arrivicheck in with the night of the ordinary. SSD singht nurse about nots have not audited night not received any other regarding noise or oth. The facility resident or 5/2/15, directed concerns will be invessionable of the complainant. The poconcerns will be invessionable of the complainant. As 13(c)(1)(ii)-(iii), (c) INVESTIGATE/REPO ALLEGATIONS/INDIVITHE facility must not eleven found guilty of almistreating residents I had a finding entered in registry concerning about report any knowle court of law against ar indicate unfitness for sother facility must ensure including injuries of unmisappropriation of residents or misappent and report any knowle court of law against ar indicate unfitness for sother facility staff to the or licensing authorities. The facility must ensure including injuries of unmisappropriation of residents of residents or misappents of unmisappropriation of residents of unmisappropriation of u	thight, acknowledging that the resident's night. SSD and in the morning, she will thurse if anything was out stated she has not asked the selevet recently and they thoise. SSD stated she had recomplaints from R42 are concerns. Incomplaints from R42 are concerns and the written or licy further directed all tigated and resolved within enuating circumstances and to and are acceptable. Incomplete the from the first from the state nurse aide use, neglect, mistreatment repriation of their property; dge it has of actions by a memployee, which would service as a nurse aide or a state nurse aide registry in that all alleged violations to neglect, or abuse, and a service as a surse aide registry in that all alleged violations to neglect, or abuse,	F 1	166	4. All resident concerns and the resoluthat those concerns were presented to resident will be reported at the month! QAPI meeting for (3) three months. A three months the QAPI committee will make a recommendation as to the need continue to monitor that the facility in the resident of the investigation and resolution of those concerns. 5. The Director of Social Services /desi will be responsible with oversight by the Administrator. Completion date of 12-2015. 1. Residents # 96 and #90 were not affine by the alleged deficient practice. Social Services has initiated weekly meetings resident # 90. Two staff members will assigned to provide cares to resident #9. All residents have the potential for that affected by the deficient practice.	the y fter l to forms ignee he 31- ected l with be 96.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245227	B. WING	B. WING		11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		•	STREET ADDRESS. CITY, STATE, 29 1601 ST LOUIS AVENUE DULUTH, MN 55802	PCODE		
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F 225	through established p State survey and cert The facility must have violations are thoroug prevent further potent investigation is in pro- The results of all inve- to the administrator of representative and to with State law (includ- certification agency) to incident, and if the all	cordance with State law procedures (including to the ification agency). e evidence that all alleged thly investigated, and must tial abuse while the gress.	F				
	by: Based on Interview a facility failed to immed potential mistreatmer and thoroughly invest mistreatment for 2 of reviewed for potentia Findings include: R90 stated he had be staff member, he had and the facility told hi about it unless he put R90's quarterly Minim 9/14/15, identified dia cerebral vascular acc	een verbally abused by a reported it to the facility, m they couldn't do anything tit in writing.					

	OF DEFICIENCIES FOURRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDE	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED
		245227	B. WING			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		. '	STREET ADDRESS, CITY, STATE, ZIP 1601 ST LOUIS AVENUE DULUTH, MN 55802	CODE	
(X4) IĐ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT: CROSS-REFERENCED TO TO PREFICIENCE	ION SHOULD BE HE APPROPRIAT	
	required extensive stamobility, personal hygplan dated 1/8/14, Indicatheter at night, and assistance every two. On 11/10/15, at 12:45 ago) his condom cathin hight. Nursing assistance angry. NA-Nito change him if he bedescribed her behavior R90 stated he reporte following day. On 11/1 member (F)-A stated in NA-N's verbal abuse the F-A stated they report (RN)-G, who told then verbal abuse by a star writing, or the facility wabout it. On 11/12/15, at 7:10 at (DON) verified there were for R90's report of verbal abuse there are ported if to the DON DON or the social wor fill out a grievance for nursing assistant amio complaint had to be in resident. At 5:48 p.m.	s continent of urine, and aff assistance with bed jiene and toiteting. The care icated R90 used a condom used the urinal with staff hours and as needed. i. p.m. R90 stated (a while eter had come off during istant (NA)-N came into his sked her to leave the ne would use the urinal, she stated she didn't have time ecame wet (with urine). R90 or as loud, rude and snotty. If the following day, and to staff the following day, as the resident's report of the member must be put in was unable to do anything a.m. the director of nursing was no mistreatment report ball abuse by NA-N. I. m. RN-G was interviewed the red R90 and F-A by NA-N. RN-G stated she and was told either by the ker R90 that F-A needed to m. RN-G further stated the n was strong, and a	F	225		

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245227 NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DIVIDITE ANN ESPACE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE	3/2015
DULUTH, MN 55802	
	(XS) COMPLETION DATE
F 225 On 11/12/15, at 5:52 p.m. the DON was interviewed, and stated R90 and F-A filled out a grievance form regarding allegad verbal abuse by NA-N. The DON stated she did not report R90's allegation of verbal abuse to the state agency, and she did not trivestigate. "It was a "he said she said" "the DON verbalized. "I have a union here," and she instructed NA-N not to go into R90's room again. On 11/13/15, at 2:10 p.m. the director of human resources (HR)-I stated she did not receive a grievance form completed by R90 and F-A, and there was no documentation in NA-N's file indicating any type of discipline regarding R90's complaint of afleged verbel abuse. On 11/13/15, at 2:16 p.m. the director of social services (SW)-B stated she did not have a grievance form completed by R90 and F-A. On 11/13/15, at approximately 2:15 p.m. the facility provided a copy of R90 and F-A's grievance form. The grievance form was dated 7/29/15, and indicated the following: "Resident's (sic) rang for staff on NOC (night) shift to come in as condom catheler was falling off. Staff (NA-N) was CNA (certified nursing assistant). Resident asked to have condom cath removed and he would use urinal rest of night, Staff responded 'no, I don't want you to piss the bed' and dermanded resident have condom cath put back on." The form was signed by RN-G and dated 7/30/15, and the DON and administrator were notified on 7/30/15. The facility policy and procedure on Abuse Prevention Plan undated, directed the administrator must be informed immediately of all	

Facility ID: 00589

		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			245227	B, WING			11/	18/2015
		ROVIDER DR SUPPLIER RE RESIDENCE & REHA	в стп		١.	STREET AODRESS, CITY, STATS, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
40	F 225	verbal abuse as the u gestured language the disparaging or deroga their families, The pot	Prevention Ptan defined se of oral, written or at willfully includes atory terms to residents or icy further directed that all ported, documented and	F	225	3. Staff were inserviced on the Al	' 1	
	2.	low back pain, general Minimum Data Set (Midentified R96 had no required extensive limperson for activities of MDS also identified RR96's care plan dated 'Resident is a vulneral injury/abuse from othe Potential for retaliation Disorder. Resident also away." Also "[R96] haverbally abusive behally	cognitive impairment and litted assistance from one flaily living (ADL)'s. The 96 as having no behaviors. 11/10/13, indicated ble Adult, at risk for ers due to cognitive deficits. It related to Bipolar so noted to give money a potential to demonstrate viors." An applicable sito give R96 as many			Neglect, and Mistreatment Policy Administrator reviewed the policy procedure with the Director of so services and the DON reviewing withem the procedures and expect for a thorough investigation. The Administrator directed the Direct Social Services to resume primary responsibility for conducting the investigation relating to any allegof abuse, neglect or mistreatment the resident. Any alleged abuse, neglect or mistreatment will be reported to the proper State age.	y and polal with sations for of dation ation ation ation	
P)RM CMS-256	said "One time I was a assistant. I was sitting sweater on. She want and I said no but she fractured my thumb. V hurting me she said 'I	abused. It was a nurse on the toilet with my ed to take the sweater off took it off anyway. She When I told her she was don't give a fuck'. I told ne as long as my thumb	manara.	Fa	olity ID: 00589 Iš continuat	ion sheet Pi	age 12 of 116

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A. BUILD:		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			16	TREET ADDRESS, DITY, STATE, ZIP CODE NOT ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH PEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	Ið ÞREFI) TAG		PROVIDER'S PLAN DE CORREC'I'ON (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 225	hurting me. Everyone need to be treated like. An Interview on 11/12 director of nurses (DC them different events R96 had a "tussle" in this event. The DON sa reported nursing assis finger. The DON said away but did not have regarding this issue. The report dated 06/3 resident was interview by this writer. She toke each time. She had for the day prior to the regrabbed something froshe had complained of Bruise is healing. The staff in question without a staff in question wit	that knows me know I don't that I cooperate". /2015, at 1:50 p.m. the low provided that had happened to her that had happened to her that said no other staff received in the next day R98 stant (NA)-T grabbed her she investigated it right to a through investigation 0/15, indicated "The red several times, including that another resident that another resident to me that same hand and that the port that another resident of the ing the resident's hand. She was also interviewed by this there was no incident of the ing the resident refused to dx [diagnosis] and has seeds staff supervision for sono findings of abuse In this lotion "The resident reports and that an aide last I during cares. Employee livestigation, and care can so in the room during cares.	F	225			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY MPLETED
		245227	B. WING			11	/18/2015
	(EACH DEFICIENC)	B CTR NYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG	16 D	TREST ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	11/17/15, at 11:13 a.m abuse to us regularly, corrolation between making reports of abu. An interview on 11/17, social services (SS)-B completing the vulner months to a year. SS-nursing at that time, be was being transitioned department again. SS do with R96's VA repositivestigation. An interview with DON p.m. said she does not investigation of the brothis is a she said/she sidlagnoses that make it. A final radiology report "There are likely dege however small avulsed completely excluded". A physician office visit "There is dark purple of the hareminence, the vithumb".	stered nurse (RN)-A on in said she (R96) reports RN-A said there is a of R96 getting her way and se. /2015, at 11:25 a.m. with slated she hasn't been able adult (VA) report for 9 B said it was transitioned to ut in the last couple weeks to be be be been able and services. B said she had nothing to out from July or the lone of the following the said she had nothing to out from July or the last and R96 has a lot of the unreliable. It dated 7/1/15, indicated the active in etiology, if fracture fragment is not dated 7/8/15, indicated ecchymosis present on the rolar wrist, and the dorsal services. MPLMENT		225	4. All allegations – and the investigat of abuse, neglect and mistreatment w presented to the QAPI monthly meeticevery month for three (3) months to monitor the thoroughness of the investigations. After three months the QAPI committee will make a recommendation as to the need to mothat the facility has properly investigated and reported all alleged abuse, neglector mistreatment. 5. The Director of Social Services/detwith oversight from the Administrator be responsible. Completion date of 12-31-2015. 1. Residents # 96 and #90 were not affected by the affected deficient praces social services has initiated weekly meetings with Resident #90. Two staffmembers will be assigned to provide a to resident #96.	ill be ng nitor ted et and ignee will	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, .		CONSTRUCTION	(X3) DATE COME	SURVEY
		245227	B. WING,			11/	18/2015
	ROVIDER OR SUPPLIER	B CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XB) COMPLETION DATE
F 226	policies and procedur	elop and Implement written res that prohibit t, and abuse of residents	F	226	All residents have the potential for affected by the alleged deficient pract	_	
	by: Based on observation review, the facility fail policy to ensure immedallegations of potential Agency (SA) and thousallegations of potential	al mistreatment to the State			3. Staff were inserviced on the Abuse, Neglect, and Mistreatment Policy. Completed 11-18-2015. The Administ reviewed the Mistreatment Policy and Procedure with the Director of Nursin the Director of Social Services and the procedures and expectations for a thor investigation. The Administrator direct the Director of Social Services to resuprimary responsibility for conducting investigation relating to any alleged a neglect and or mistreatment. Complet 4-2015.	trator g and cough sted me the buse,	
	R90 stated he had be staff member, and the the SA, and thorough. The facility policy and Prevention Plan unda administrator must be incidents. The Abuse verbal abuse as the Ligestured language the disparaging or derogatheir families. The polincidents are to be reinvestigated Internally R90's quarterly Minim 9/14/15, identified diacerebral vascular according to the control of the	I procedure on Abuse sted, directed the sinformed immediately of all Prevention Plan defined use of oral, written or at willfully includes atory terms to residents or icy further directed that all ported, documented and			 4. All allegations and the subsequent investigations will be presented at the monthly QAPI meeting for three mon monitor that the faculty followed its F on Mistreatment. After three months to QAPI committee will make a recommendation as to the need to monthat the facility has properly investigal and reported all alleged abuse, neglect of mistreatment. 5. The Director of social services with oversight from the Administrator will responsible. Completion date of 12-3- 	ths to folicy he nitor ted a and be	

Facility ID: 00589

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	•	245227	B. WING	·		11/18/2015
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STA16, ZIP 1601 ST LOUIS AVENUE DULUTH, MN 55802	CDDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TIÓN SHOULD BE THE APPROPRIAT	
	required extensive stamobility, personal hygplan dated 1/8/14, indicatheter at night, and assistance every two. On 11/10/15, at 12:45 ago) his condom cathine night. Nursing assistance angry. NA-N to change him if he behavior as loud, he reported NA-N's veday. On 11/12/15, at 1 (F)-A stated she went verbal abuse to staff they reported to regist told them a resident's staff member must be was unable to do anyt. On 11/12/15, at 7:10 at (DON) verified there we for R90's report of verified the ported it for the DON DON or the social wor fill out a grievance for nursing assistant union complaint had to be in resident. At 5:48 p.m.	s continent of urine, and aff assistance with bed alene and toileting. The care icated R90 used a condorn used the urinal with staff hours and as needed. i. p.m. R90 stated (a while eter had come off during alstant (NA)-N came into his sked her to leave the ne would use the urinal, she stated she didn't have time acame wet. R90 described rude and snotty. R90 stated erbal abuse the following 12:24 p.m. family member with R90 to report NA-N's he following day. F-A stated ered nurse (RN)-G, who report of verbal abuse by a put in writing, or the facility hing about it. a.m. the director of nursing was no mistreatment report ball abuse by NA-N. b.m. RN-G was interviewed abered R90 and F-A by NA-N. RN-G stated she and was told either by the ker R90 that F-A needed to m. RN-G further stated the news strong, and e	F2	226		

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(XS) DATE COMP	SURVEY LETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE. ZI 1601 ST LOUIS AVENUE DULUTH, MN 55802	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OUTICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT		(XS) COMPLETION DATE
F 226	On 11/12/15, at 5:52 Interviewed, and state grievance form regard NA-N. The DON state allegation of verbal at and she did not invest said! " the DON verband she instructed Naroom again. On 11/13/15, at 2:10 resources (HR)-I stat grievance form compitere was no docume indicating any type of complaint of alleged at 2:16 p.m. the direct (SW)-B stated she diccompleted by R90 and On 11/13/15, at apprefacility provided a congrevance form. The grievance form. The grievance form the grievance form the sacondom catheter was CNA (certified in asked to have condowould use urinat rest ino, I don't want you it demanded resident hor." The form was sig 7/30/15, and the DOI notified on 7/30/15.	p.m. the DON was ed R90 and F-A filled out a ding alleged verbal abuse by ed she did not report R90's buse to the state agency, digate. "It was a 'he said she atized, "I have a union here," A-N not to go into R90's p.m. the director of human ed she did not receive a leted by R90 and F-A, and entation in NA-N's file of discipline regarding R90's everbal abuse. On 11/13/15, eter of social services d not have a grievance form and F-A. eximately 2:15 p.m. the early of R90 and F-A's grievance form was dated d the following: "Resident's NOC (night) shift to come in was falling off. Staff (NA-N) ursing assistant). Resident m cath removed and he of night. Staff responded to piss the bed' and have condom cath put back gned by RN-G and dated N and administrator were	F	226			
	back pain, generalize Minimum Data Set (N	ed arthrills. The quarterly ADS) dated 10/19/15,					

Facility ID: 00589

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		DATE SURVEY COMPLETED
		245227	B. WING			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP COI 1601 ST LOUIS AVENUE DULUTH, MN 55802	DE	
(X4) ID PREFIX TAG	(BACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	JD PREFIX TAG	PROVIDER'S PLAN OF GOI (IBACH CORRECTIVE ACTION GROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	required extensive limperson for activities of MDS also Identified R An interview on 11/10 "One time I was abus I was sitting on the tole wanted to take the swishe took it off anyway. When I told her she widon't give a fuck'. I tole as long as my thumber much of a penalty for knows me know I don't active of a nurses (DC them different events had a "tussie" in the srevent. The DON said report. The DON said nursing assistant (NA) DON said she investig not have a through invisue. The report dated 06/3 resident was interview by this writer. She told each time. She had fo the day prior to the regrabbed something froshe had complained of Bruise is heafing. The staff in question witer, and stated that	cognitive impairment and litted assistance from one if daily living (ADL)'s. The 96 as having no behaviors. 115, at 12:50 p.m. R96 said ed. It was a nurse assistant, let with my sweater on. She reater off and I said no but . She fractured my thumb. as hurting me she said 'I deveryone, she was gone was healing. That isn't hurting me. Everyone that it need to be treated like 12015, at 1:50 p.m. the IN) said R96 kept telling that happened to her . R96 noking area, a fall and this no other staff received a the next day R96 reported a tright away, but did restigation regarding this	F 2	226		

MANE OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR SUBJECT TO THE SUPPLIES SUPPLIE		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
PAYSHORE RESIDENCE & REHAB CTR PAYON D SUMMARY STATEMENT OF DEFICIENCIES (EARD DEFICIENCY MUST BE PRECISED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			245227	e. WNG			11/	18/2015
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F226 CONTINUED From page 18 had helped her remove a shirt, and a bit later offered help with cares which resident refused. Resident has multiple dx (diagnosis) and has been angry that she needs staff supervision for her smoking. There is no findings of abuse in this case." Under incident description "The resident reports that her hand is sore, and that an aide last evening hurt her hand during cares. Inheestigation. An interview on 11/17/2015, at 11:25 a.m. with social services (SS)-B who said she hasn't been doing the vulnerable adult (VA) for 9 months to a year. She said it was transitioned to runsing at that time but in the last couple weeks was being transitioned back to the social services department again. S-S-B said she hed nothing to do with Refe's VA report from July or the investigation of R96's VA report from July or the investigation of R96's broken finger. The DON said this is a she said/she said and R96 has a lot of diagnosis that make her unreliable. A final radiology report dated 7/f/15, indicated "There are likely degenerative in etiology, however small avulsed fracture fragment is not completely excluded." A physician office visit dated 7/8/15, indicated "There is dark pumple ecolymosis present on the			B CTR		160	11 ST LOUIS AVENUE		
had helped her remove a shirt, and a bit later offered help with cares which resident refused. Resident has multiple at ydiagnosis] and has been angry that she needs staff supervision for her smoking. There is no findings of abuse in this case." Under incident description "The resident reports that her hand is sore, and that an aide last evening hurt her hand during cares. Employee suspended pending investigation, and care can changed that 2 staff be in the mom during cares. Investigation ongoing." There is no further investigation. An interview on 11/17/2015, at 11:25 a.m. with social services (SS)-B who said she hasn't been doing the vulnerable adult (VA) for 9 months to a year. She said it was transitioned to nursing at that time but in the last couple weeks was being transitioned back to the social services department again. SS-B said she had nothing to do with R96's VA report from July or the investigation. An interview with DON on 11/17/2015, at 3:01 p.m. said she did not have any further investigation of R96's broken finger. The DON said this is a she said/she said and R96 has a lot of diagnosis' that make her unreflable. A final radiology report dated 7/1/15, indicated "There are likely degenerative in eticlogy, however small avulsed fracture fragment is not completely excluded". A physician office visit dated 7/8/15, indicated "There is dark purple ecchrymosis present on the	PRÉFIX	(EACH DEFICIENC)	Y MUST 96 PRECEDED BY FULL	PREFI	ς	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
thenareminence, the volar wrist, and the dorsal thumb".	F 226	had helped her remove offered help with care Resident has multiple been angry that she in her smoking. There is case." Under incident description that her hand is sore, evening hurt her hand suspended pending in changed that 2 staff is investigation ongoing investigation. An interview on 11/17 social services (SS)-fidding the vulnerable syear. She said it was that time but in the last transitioned back to the department again. SS do with R96's VA reprinvestigation. An interview with DOI p.m. said she did not investigation of R96's said this is a she said of diagnosis' that male A final radiology report There are likely degand however small avulse completely excluded." A physician office visi "There is dark purple thenareminence, the	we a shirt, and a bit later is which resident refused. It (diagnosis) and has beeds staff supervision for in o findings of abuse in this pition "The resident reports and that an aide last it during cares. Employee investigation, and care can be in the room during cares." There is no further 1/2015, at 11:25 a.m. with 3 who said she hasn't been adult (VA) for 9 months to a transitioned to nursing at st couple weeks was being the social services in a said she had nothing to bort from July or the N on 11/17/2015, at 3:01 have any further in broken finger. The DON is he said and R96 has a lot to the her unreliable. It dated 7/1/15, indicated enerative in etiology, and fracture fragment is not it dated 7/8/15, indicated ecchymosis present on the	F	226			

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA REATIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COME	SURVEY PLEYED
		245227	B, WING_			111	18/2015
NAME OF P	RÖVIDER OR SUPPLIER	277441	,	STREET ADDRES	SS, OTTY, STATE, ZIP CODE	111	10/2015
				1601 ST LOUIS			
BAYSHO	RE RESIDENCE & REHA	BCTR	İ	DULUTH, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PROFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACITION SHOULD BE S-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(XS) COMPLETION DATE
F 241 SS=D	not received. R96's care plan dated "Resident is a vulnera injury/abuse from othe Potential for retaliation Resident also noted to "[R96] has potential to abusive behaviors." A this was to give R96 a possible. An interview with regist 11/17/15, at 11:13 a.m abuse to us regularly. correlation between R making reports of abust 483.15(a) DIGNITY All INDIVIDUALITY The facility must prominance and in an envious enhances each reside full recognition of his control of the control of th	es were requested but were 11/10/13 indicated ble Adult, at risk for ers due to cognitive deficits. In related to Bipolar Disorder. In glve money away." Also In demonstrate verbally In applicable intervention to Its many choices as Itered nurse (RN)-A on Its said she (R96) reports RN-A said there is a Itered not getting her way and Itere	F 2	1 Resider outcomes practice, seadditional she has she has she 2. Resider make cho communic have the palleged de 3. Resider include by concernin preferred conversate in-service dignity re interaction or issues i assisted to dignified to be conduct weeks to re appropriate staff interaction in the resider dignified to immediate the resider dignified to residents i environme cach resider	ant # 49 has had no negative a from the alleged deficient Social Services purchased I items of clothing for R49, whown acceptance, and the ability cate likes and dislikes or need potential to be affected by the efficient practice. Into will be assessed which man that not limited to making choing clothing, grooming, name to be called, and or appropriation with resident, etc. staff weld on areas that relate to dignificated to resident care with residentified via assessment are assure that needs are met in method. Observation rounds etch two times per week for I monitor that residents are tely dressed, groomed and the action are appropriate. Any occurrence will be addressed city. Staff will be in serviced and read and promote care for in a manner and promote care for in a manner and promote care for in a manner and residential and respect in fine of his or her individuality.	ty to y to ds e ay ces they ate ill be sity, sident eeds will 2 at	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATS COMP	SURVEY LETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		18	REGT ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	REFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	included failure to thri restlessness and agit: annual Minlmum Data indicated R49 had serequired extensive as transfers, dressing, earlygiene, and was free bladder and bowel. On 11/9/15, at 3:46 p the second floor dining snapped up the back, snapped and R49's to incontinent product w On 11/13/15, at 12:48 second floor dining redown the right side of that R49's entire right When asked if R49 us off-shoulder, Nursing "Not usually". During her hot chocofate on I floor. On 11/13/15, at 1:30 observation, R49 was wheelchair in front of station. R49 was no shirt or pants, but had that snapped down the clothing only went haleaving her knees and Because R49's lower	rd indicated diagnoses that ve, depression, ation and diabetes. R49's a Set (MDS), dated 7/8/15, verely impaired cognition, sistance with bed mobility, ating, toileting and personal quently incontinent of	F	241	4 Observation rounds will be condutwo (2) times per week for 12 weeks monitor that residents are dressed and groomed in a dignified manner. Any negative occurrence will be addressed immediately. The observation round documentation will be presented to the monthly QAPI committee for three to monitor the facility's system of hat the resident's dressed and groomed in dignified manner. After three months QAPI committee will make a recommendation as to the need to conto monitor that the facility consistent practices that the resident's right to be dressed and groomed; that the facility promotes care for residents in a mantomaintains or enhances each resident' dignity and respect in full recognition their individuality. 5. The Administrator/designed will be responsible. Completed 12-18-2015.	d d ne months ving n a the ntinuc ly e y ner that s n fo	

	OF DEFICIENCIES FIGURECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, 7	TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245227	Ø.WING_			11	/18/2015
	(EACH DEFICIENC)	B CTR ATEMIENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SCIDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP COI 1601 ST LOUIS AVENUE DULUTH, MN 55802 PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION I SMOULD BE APPROPRIAT	Ë	(XG) GOMPLETX(X) OATE
F 242	dated 10/09, directed maintain and protect reported to bodily privacy. 483.15(b) SELF-DETE MAKE CHOICES The resident has the reschedules, and health or her interests, assess care; interact with melboth inside and outsid choices about aspects facility that are significable to honor choices for 1 of 3 resident for choices. Findings include: On 11/9/15, at 2:49 p.m. R146 would like to be be daily prior to admission had given this information responded by tefling hir week. R146 was presented and responded in agriculture.	ed Quality of Life-Dignity staff shall promote, resident privacy, including and an arrivacy, including and an arrivacy, including and arrivacy, including and arrivacy, including arrivacy, including arrivacy, including and plans of an arrivacy and plans of an arrivacy and plans of an arrivacy and make arrivacy and make arrivacy and make arrivacy and arrivacy and arrivacy of bathing arrivacy of bathing arrivacy of bathing arrivacy of bathing and arrivacy and arrivacy a	F2	A family care conference	s family wo nd changed er, the residential to be ient practic m was ng a Reside emination:	ould d dont dent ee.	

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STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		2 45227	в. мия			11/	18/2015
NAME OF PROVIDER OR BAYSHORE RESIDE (X4) ID	NCE & REHA	AB CTR	l ID	16	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE ULUTH, MN 65802 PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX (E	ACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRESI) TAG		(EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
(RN)-C s weekly be 1 or 2 bathed to the facilither preference week, an previous On 11/18 (DON) we expect the bathing of The facility - Accomplete and anges 483.20(d SS=D PARTICI The residincomperincapacity participal changes A compression of the compression of	ing. 7/15, at 9:48 tated the face ath day upon this a week, wice a week, wice a week, by had asked arence for more detailed as interviewed as interviewed accommodation of ent's individuaccommodation of the ent's individual ent's individual ent's individual ent's ent	a.m. registered nurse cility assigned residents a n admission, and will provide RN-C stated R146 was however she was unsure if R146 or her family member ore then one or two baths a re if they asked about her dine. 4 p.m. the director of nursing ad and stated she would nor resident choices for diprocedure on Quality of Life Needs dated 10/09, directed all needs and preferences ted to the extent possible, lith and safety of the sidents would be (k)(2) RtGHT TO INING CARE-REVISE CP right, unless adjudged wise found to be he laws of the State, to g care and treatment or		242	 4. The resident's right for self-determination and choices will be disc with the resident and of guardian upon admission. And The Interdisciplinary will review each resident's right to sel determination and choices in their planeare at each quarterly care conference Initiated 12-1-2015. 5. An audit will be completed each me for the next three months to monitor the choices are offered and documented in Plan of care. Audits will be presented monthly QAPI committee for three me and then quarterly for the next year to monitor that a system assuring self-determination and resident choice is functioning. 6. The Director of Social Services / designce will be responsible with over by the Administrator. Completion date 12-31-2015. 1 Residents #152, who was on Hospite has documentation that weight loss is unavoidable; however resident does a meals in her room where staff offer chand encourage resident to cat. Reside has scheduled pain medication and documented as effective. 	reach Team If- If- In of In of In of In the It the	

Facility ID: 00589

	OF ØEFICIENCIES : CÓRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·		CONSTRUCTION		E SURVEY PLETEO
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 66802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	AFEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFIX TAG		PROVIDER'S PLAN OF GORRECTION (EACH CORRECTAVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X6) COMPLETION DATE
F 280	disciplines as determined, to the extent practitude resident, the resident practitude resident, the resident practicular revised by a team each assessment. This REQUIREMENT by: Based on observation review, the facility fails care to include the modessessment for 1 of 1 from post tramatic hears gaurgical intervention. In addition, diefician's 4 residents (R65) reviewed in addition, the facility fails of care for 1 of 1 in need of pressure ultimated in the resident of the re	wher appropriate staff in med by the resident's needs, edicable, the participation of ent's family or the resident's and periodically reviewed in of qualified persons after is not met as evidenced in, interview and document ed to revised the plan of ederate to severe pain (R61) reviewed for pain and acetabulum fracture, recommendations for 1 of ewed for dietary concerns colity did not update the residents (R152) reviewed cer prevention/treatment.	F2	280			
	R61's admission recor	d indicated a diagnosis of		Ц			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION UMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING_			11/	18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STRES 1601 : DULU				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)		PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
F 280	admission Minimum I 10/29/15, indicated R impaired, had no beh in the past seven day had pain, and receive was at risk of falls, an more falls without injute Pain assessments da 11/10/15, were analybeing awaken from the awaken in the night farated moderate to set dated 9/8/15, indicate medication every 3-4 10/29/15, and 11/10/1 and pain medications. An interview on 11/12 I'm okay but my legs. An observation of R6 a.m. lying in his bed wo pillow under them. Wat a 8/10 (on a verbal and 10 was the most. An Interview with Reg 11/16/2015 at 4:07 p. in a lot of pain and ag control. She said all the same pain scale and She will get all staff ushe said they do not pain interventions and	ession, hypertension, onary artery disease. R61's Data Set (MDS) dated 61 was severely cognitively avior problems, and felt sad s. The MDS identified R61 ad pain medication daily, and ad had a history of two or ary, and a fall with injury. Ited 9/8/15, 10/29/15 and red and R61 went from not be pain in the night to being from the pain. The pain was were on all. The assessment ad R61 only needing pain days, but the two dated f5 both indicated dally pain needed.	F	280				

	OF DEPICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(XS) DATE SURVEY COMPLETED	
		245227	B. WING			11.	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1	STREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE PULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	PREFIX TAG	4	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	review the medication scheduled a pain medicalities request. We been here he doesn't his pain may be affect requested a regular pain order is for oxyco. The medical doctor all medications. RN-A als any behaviors. R152 dld not have a condeveloped to minimize and promote healing of According to the under admitted on 5/28/15, neuroendocrine carcinobstruction and significare Area Assessmen R152 had the "potentialicers. The care plan dated a identified a goal of has interventions identified protocols and policies documentation. There interventions in place potential for skin break A progress note dated had mepiplex on his coadmission for "prevential physician order dated (foam dressing) to the physician order directed Optifoam dressing (an	d the medical doctor will s. The medical doctor lication because of the realize since you have have good pain control and fing his relentlessness and ain medication. His new done 10 mg 3 times daily, so reviewed his other so said R61 does not have comprehensive care plan the the risk of development of pressure ulcers, ted face sheet, R152 was with metastatic froma, inferior vena cava cant nutritional deficits. A find dated 6/5/15, identified all to develop pressure s initiated on 6/5/15, lying Intact skin. The i included following facility and weekly treatment were no individualized to minimize the identified down. 5/28/15 revealed R152 becyx at the time of fative measures." A 6/17/15, identified mepiplex coccyx. On 6/19/15 a ad staff to place an absorbent all in one wound re barrier on the outside) to	F	280			

	(7EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		1, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245227	B. WING_			11/18/2015	
•	ROVIDER OR SUPFLIER RE RESIDENCE & REHA	BCTR		STREET ADDRESS, DITY, STATE, ZEP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	<u> </u>		
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F 280	noted on the right but (cm) by 2 cm. A week completed 6/20/15, id but then identified "sk further assessment. F On 11/17/15, at 12:56 (RN)-A stated there were for R152. RN-A stated finalized for R152 yet. On 11/18/15 at 8:35 at (DON) stated she received R152. "n DON stated she woul record and would proon 11/18/15 at 10:00 copies of documentat "everything we have a review of the document information provided, planning content. R158's significant characteristic contents and significant characteristic contents and planning content. R158's significant characteristic contents and significant characteristic contents. R158's care plan date R158 was at risk for recompleted for risk for recompleted for risk for risk was at risk for recompleted for recomplet	e identified skin breakdown tock measuring 2 centimeter by skin assessment entified the skin was intact in broken at coccyx" with no k152 expired on 7/5/15. In m. Registered Nurse was no further care planning the care plan hadn't been the care plan hadn't been alled R152. The DON stated ever really opened up." The dhave to look at R152's vide additional information. I.m. the DON provided ion and stated it was on the wounds." Upon onts, there was no additional including no other care ange Minimum Data Set indicated R158 had inpairments. The MDS independent with eating after the in weight loss indicated. Agnoses of cancer and and 10/9/15, indicated nutrition secondary to fluid set and infection problems. It: iet as ordered record every meaf	F 2	80			

	OF DEFIGIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER	B CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 56802			
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F 280	Continued From page	27	F:	280			
	an order for a regular lacked an order for a r R158's Weights and \ the following weights:	(lbs) -10% weight change weight change cord from 9/15/15, to following meal Intake		111111111111111111111111111111111111111			
	 55 meals at 51% - 7 27 meals at 76% - 1 The medical record lanutritional reassessmenthe care plan. 	00% cked evidence of a					
	On 11/17/15, at 8:03 a eating in the dining rook R158 was served hot of frozen brange juice During the observation coffee and and was seduring breakfast, R158 eat throughout the mejelly on her toast, staff brown sugar or ralsins	n R158 asked for more erved a total of 3 cups 3 was being encouraged to al and was assisted to put					

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEMONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245227	8. WING			11/	18/2015
BAYSHOR	ROVIDER OR SUPPLIER		ID	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 55802			(X6)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	FREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFIGIENCY)		GOMPLETION DATE
F 280	member did not offer R158 ate 75% of hot toast, leaving the crus of coffee, 1/2 of her n R158 stated "I've had On 11/17/15, at 12:23 eating independently lunch meal. R158 wawith whipped topping 8 ounces (oz) of milk 100% of the oranges only bites of the taco R158 drank 100% of the observation R158 dining room ticket and her fork and not take the fork back down. From the dining room back to her room via When interviewed on registered dietician (Fibe weighed monthly and food Intakes are dietician. The RD furt decline in weight and would be reassessed further weight loss. The difficult case as she however stated R158 process. Upon review compared to the weighter RD stated R158 via the RD stated R158 via th	aff member to eat. The staff R158 anything else to eat. cereal, bites of eggs and her st. R158 consumed 3 cups tilk and no orange juice. The enough." It p.m. R158 was observed in the dining room for the served a cup of oranges, tace hotdish, mexican corn, and 8 oz of coffee R158 ate and whipped topping and hotdish and mexican corn. The milk and coffee. During the was busy playing with her downld frequently pick up a bite of food and then put length and propelled herself table and propelled herself table and propelled herself ther wheelchair. 11/18/15, at 9:05 a.m. the RD) stated residents are to at a minimum and weights reviewed monthly by the her stated if there is a food intake the resident for interventions to prevent the RD stated that R158 was a was on hospice care, its not actively in the dying of the RD's spreadsheet that in the medical record was not looked at for a of the RD inputting R158's	F	280	2. all residents have the potential to hat issues with care planning. 3IDT members and licensed staff with complete in-service on care planning including updates as needed for change status or condition, to be completed by 12/18/15. Care plans will be reviewed quarterly and discussed with resident family, and updated as needed; care plane reviewed updated as needed with a change in condition such as, but not exclusively, falls, skin issues, changes mentation or ADL status.; the Nurse Managers will recheck that care plans care sheets are updated with above chefully the provided with above cheful to the DON will be responsible and regulation will be provided to staff as needed. 5. The Director of Nursing /designee with provided to will be completed on or be 12-31-2015.	ill ge of y and or lans my and anges, cort ic cort icr eport inther	
	residents weight to or	ompare subsequent weights mission weight of 131.9 lbs					

Event ID: GYOR11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING		11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUILL SCIDENTIFYING INFORMATION)	IÚ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 282	been reassessed for p 483,20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by c accordance with each care. This REQUIREMENT by: Based on interview at facility failed to follow plan to prevent pressuresidents (R22) review R22's quarterly Minim 9/25/15, indicated R22 Impairments and requivith bed mobility and I transfers. The MDS in diabetes mellitus, hem palsy. The MDS indicapressure ulcer (partial presenting as a shallo pink wound bed, without unhealed and was not previous assessment. R22's care plan dated resident had a pressur ischium (forms the low hip bone), Intervention administer medication.	Distated that she had her review and should have cossible interventions. ICES BY QUALIFIED E PLAN If or arranged by the facility qualified persons in resident's written plan of the intervention on the care are ulcers for 1 of 4 and severe cognitive intervention on the care are ulcers. It is a severe cognitive in the cluded diagnoses of a sistence with cluded diagnoses of a sistence are ulcers loss of dermis and cerebral atted R22 had a stage 2 thickness loss of dermis are open ulcer with a reduct slough), that was a present at the time of the sincluded; in a sordered and monitor in the sa ordered and monitor in the same and the	F 282	1 .Resident # 22 is followed by the WC	and Cusing c skin sident Tisk skin ed to on the ea and PI e a nue ons	

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	DI AN OF CODDECTION ADENTIFICATION AND IMPER		1, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
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F 262	predicating pressure tolerance [assessmen schedule] quarterly at a monitor nutritional significant reposition. PRN in wheelchair arthistory of refusing. Frequires an alternational record comprehensive skin reduced to more quarterly and PR22's medical record comprehensive skin reduced from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The foliater June of 2015 we assessments related to the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly	the MD It, Braden [assessment for ulcer risk] and tissue int for repositioning and as needed (PRN) tatus, serve diet as ordered twice daily and PRN to skin, bony prominences of from staff for ing every two hours and and bed, resident has a ang air mattress on his bed chair. Lacked evidence of a risk assessment, to be RN per the care plan. acked a Tissue Tolerance are quarterly and PRN per dical record lacked any or tissue profusion. Lacked evidence of an assessments since lowing skin assessments are dated 7/1/15, 8/19/15, 15. recorded indicated the stage discovered on 9/2/15, and ters (cm) x 0.5 cm x a depth Vound base was 90% red and was moist in the, no odor. Surrounding blanched. Writer applied and will seek physician a place include alternating	F	282			

Facility 3D. 00688

PRINTED: 12/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (XI) PROVIDENSUPPLIER/CIUA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(XS) DATE SURVEY COMPLETED				
			245227	B. WING			11/	11/18/2015	
		ROVIDER OR SUPPLIER RE RESIDENCE & RE	EHAB CTR		15	REET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 65802			
	(X4) 1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC (DENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD OROSS-REFERENCED TO THE APPROPE DERCIENCY)	BE	(X5) COMPLETION DATE	
	F 282		on 11/17/15, at 2:19 a.m.	Fá	82				
		a quarterly Braden is observation on residence as never seen that type in the facility. RN-B	N)-B stated that the nurses do Scale and weekly skin dents, but they do not use a seesment and added she has e of assessment since starting verified that the weekly skin not completed weekly as eare	-					
		stated the facility do	on 11/17/15, at 2:38 p.m. BN-H bes not use a Tissue Tolerance essing for appropriate itloning schedules.						
	F 2 8 5 88-0	director of nursing (are on a every 2 hor and that the nurses determine an appro- for residents. The D was repositioned tim- plan. The DON state specific tool to asse DON further stated should be complete	on 11/18/15, at 10:20 a.m. the DON) stated that all residents urs repositioning schedule utilize the Braden Scale to priate repositioning schedule DON further stated that B22 nely according to his care ed the facility does not use a ass for tissue profusion. The that weekly skin observations d and documented.	FŞ	65				
		pre-admission scree program under Med	linate assessments with the ening and resident review licaid in part 483, subpart C to it practicable to avoid and effort.						
			rst not admit, on or after ly new residents with:						

FORM CMS-2567(02-98) Previous Varsions Obsolete

Event ID: GYQH11

Event ID: GYCHII Facility ID: 00589 If continuation sheet Page 32 of 116

Administration

12.31.20(5)

		(X:) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	1 7 .	RECONSTRUCTION		(X3) DATE SUBVEY COMPLETED	
		245227	B. WING		11/	18/2015	
	(EACH DEFICIENC)	EHABIOTR TEMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		STREET ADDRESS, CRY, STATE, ZIP C 1601 ST LOUIS AVENUE DULUTH, MN 55892 PROVIDER'S PLAN OF CO (LACH GOIRRECTIVE ACTION GROSS REFERENCED TO THE DUTICIONOY)	CODE RRECTION 1 6HOULD 3L	(XG) COMPLETION DATE	
F 286	(i) Mental illness a (ii) of this section, unauthority has deternindependent physic performed by a pen State mental health (A) That, because condition of the indition of this section of this section of the indition of the individual is and (B) If the individual is illness defined at \$4 (II) An individual is retarded if the individual is retarded in \$483.102 related condition as This REQUIREMEN by: Based on Interview	s defined in paragraph (m)(2) nless the State mental health nined, based on an all and mental evaluation son or entity other than the authority, prior to admission; of the physical and mental vidual, the individual requires provided by a nursing facility; all requires such level of the individual requires for mental retardation. In a defined in paragraph tion, unless the State mental opmental disability authority or to admission— of the physical and mental vidual, the individual requires provided by a nursing facility; all requires such level of the individual requires of the physical and mental vidual, the individual requires are individual requires as for mental relardation.	F 285	1. The facility did re Level II PASSR for #146 and no outs resources/interve were required for resident. 2. Four residents we identified in the frequiring a Level None of the resident required outside resources/interversidents required for residents requiring programming new Director of Social The Director of Social The Director of Social The Director of Social The Level II residents in the Level II PAS requiring special programming.	r resident side entions r the ere facility II PASSR. dents entions. or reviewed r Level II ng eds with the I Services. ocial ude a f care for all identified		

		(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY CXMPLETED	
		245227	Ð, WING		11/	18/2015	
	PROVIDER OR SUPPLIER	EHAB ÇTR	1	THEET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE DULUTH, MN 55802			
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F 285	and Resident Reviet 1 residents (R146) is developmental disal Elndings include: R146's Admission Fithat included Down'dated 8/17/15, lacke troatmont needs. R146's Level II PAS R146's Level II PAS R146 had a develop required convalesce 10/6/15. The Level II R146'required active treat specified in R146's would be met while facility. On 11/13/15, the fact a copy of R146's Level II PASRR, and received a copy of it SW-A verified the fact Level II PASRR preserved in R146's R146 participate in 10 n 11/18/15, at 9:4 county's responsibility received the Level II currently walting for county worker. SW-	II Preadmission Screening by (PASRR) evaluation for 1 of reviewed with a bility. Record identified diagnoses a syndrome. The care planed indication of active. RR dated 8/10/15, indicated organized disability, and ent care from 8/6/15, to 1 PASRR further identified a treatment, and the facility ment needs will have been individual service plan, and R146 resided in the nursing bility was requested to provide vel II PASRR, On 11/17/15, A provided a copy of R146's distance the facility had just from the county via fax. utility had not reviewed R146's	F 285	An audit of all residents and all admissions requiring a Level II screen and assed as needing speprogramming will be conducted every month to monitor that specialized plans of care have be developed for these residents. 4. the audits will be presented to monthly QAPI committee for the months. After three months the QAPI committee will make a recommendation as to the need continue to monitor that Level I residents have the PASSR and specialized care plan. Complettion date of 12-31-2015	ecial o the ree		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING		E SURVEY IPLETED			
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F 285	she spends a lot of A policy and proced	time in her room. lure on Level II PASRR	F 285					
		quested, but not provided. CARE/SERVICES FOR EING	F309		LABOURDON A.			
	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain lest practicable physical, social well-being, in a comprehensive assessment	-					
	by: Based on observative review, the facility facility facility facility facility facility facilities assess pain and imprelleve moderate to (low back) and acet fractures for 1 of 1 pain. This deficient to R61. In addition, coordination of care hospice agency for reviewed for hospic provide services to aphysician for 1 of 1. Findings include: H61's admission rediagnoses including	cord identified multiple traumatic subdural						
	hematoma, lumbar	compression fracture and hip ission Minimum Data Set						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLFA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		245227	B. WING_			11	/18/2015
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F 309	problems. The MDS in received pain medicar falls with a history of further identified R61 assistance of one stat (ADLs) and had not a days. Pain assessments we 10/29/15 and 11/10/15 night from the pain. The dated 11/10/15, identificated 11/10/15, identifications needed. The Care Area Asses 10/29/15, indicated vemoaning, groaning, arpain. The characteris of the pain was not codated 11/3/15, identificate plan directed pair monitor for and report appetite and verbal/no pain. The care plan dinon-pharmacological alleviate pain. The Medication Admir 9/15, 10/15, and 11/15 started receiving oxyconeeded (PRN) on 10/2 survey) when the med provide pain medicatic oxycodone was given	indicated R61 was inpaired and had no behavior dentified R61 had pain and then daily, and was at risk of alls with injury. The MDS required extensive if for activities of daily living imbulated the past seven in the pain was rated moderate most recent assessment fied daily pain and pain in the pain was rated moderate most recent assessment if it is in the pain was rated moderate most recent assessment if it is in the pain was rated moderate in the pain was rated moderate most recent assessment if it is in the pain was rated moderate it is, frequency and intensity in mpleted. R61's care plan and a potential for pain. The in medications as ordered, changes in routine or in-verbal complaints of it include any interventions to help its in the pain in the p	F	809	Mon-Fri and the nurse managers review any resident changes or /is Any issues with follow through an addressed with staff immediately, education is provided as needed. 4.The DON reports any issues to t QAPI monthly. After three months QAPI committee will make a recommendation as to the need for reeducation or revisions to the process. Completion date of 12-31-2015.	he s the	

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	DF DEFICIENCIES CORRECTIÓN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVE	
		245227	B. WING		11/18/20	15
	ROWDER OR SUPPLIER RE RESIDENCE & REHA		15	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE ULUTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC [DENTIFYING INFORMATION]	ID PREIFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMI	(XB) FLETION IATE
F 309	An observation of R6 a.m. lying in his bed will pillow under them. What a 8/10 (a verbal parain and 10 was their An interview on 11/9/therapist (PT)-A ident R61 10/22/15, to 10/3 to current. She said withospital after his subchad orders for all threoccupational, speech PT-A stated they use (facial pictures) with FPT-A continued to stareferral they only saw attempted to ambulate ambulate. He could obed to chair with a weal to of pain cause of The next request for fill/3/15, after returning fracture from another weight bearing as disciplines evaluated (transcutaneous efect his pain. R61 rated his pain. R61 rated his pain. R61 rated his pain. An interview on 11/12 therapy assistant (PT pain using the Wongrated his pain a 10/10 the sain and the pain and the pain and the sain and the sain and the sain and the wongrated his pain a 10/10 the sain and the wongrated his pain	doses which could have 1 on 11/12/2015, at 10:38 with his knees up and a fren asked he rated his paln in scale where 1 was no most pain he has ever had). 15 at 1:00 p.m. with physical ified they had started seeing itified they had started his s	F 309			

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1				TE SURVEY MPLETED	
		245227	B, WING_				/18/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST 82 PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 309	11/9/15. She slated the too short for R61. She grest had not been R61's leg on a stool a PTA-A told PT-D that leg rest as the leg rest as the leg rest short for him. R61 months whole time PTA-A was repeatedly said "it hur At 8:54 a.m. PTA-A as was and he said 10/10 continue the therapy oballoon to play ball. A subsequent intervie PTA-A said R61 has releg due to pain. PTA-bearing as tolerated believel. She said she us after an injury but has "extreme pain." She segave him something for important to have schelling as tolerated because of his back a pillow between R61's wouldn't straighten his say R61's wheelchair hurt him. A 10:38 a.m. while R61 the rest wouldn't straighten him.	at 8:13 a.m PTA-A ed R61's wheelchair on he leg of the wheelchair was e could not explain why the adjusted for R61. PTA-A put his leg kept falling off the t on the wheelchair was too baned and whimpered the s moving his leg. R61 ts" and "ouch, ouch, ouch." sked R61 what his pain level D. PTA-A was not able to on his legs so she used a w on 11/12/15, at 9:02 a.m. hot been able to move his A stated he was weight but can't walk due to his pain housily walks people sooner hot walked him due to be added pain medications. at 10:11 a.m. nursing d R61 cried out in pain a lot hid hip injury. He said the legs in bed was because he seleg out. She went on to did not fit him and the han interview on 11/12/15, at was lying in bed, this writer pain and he rated his pain		309				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA ///DENT/F/CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(XS) DATE COMP	SURVEY PLETED
		245227	8. WING			11/	18/2015
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F 309	rated his pain as 10/1 is still able to move at with therapy. PT-A siboard to the Nu Step PT-A sald there were interventions used for didn't know why the TPT-A said when physevaluation on 11/6/15 said they changed his didn't fit him well. PT-leg didn't f	y are in pain. She said R61 0. PT-A said if the resident of transfer they go ahead aid he used the sliding but R61 grimaced in pain. In one pharmacelogical of R61's pain today. She rendered it pain today. She rendered it pain today. She rendered it pain today is wheelchair because it is and his leg kept sliding off mair. She said they put a calfining after the discussion 8/15, at 8:47 a.m. (OT)-K asked R61 to rate it at a 6/10 located near his she would tell the nurse. 15, at 2:28 p.m. that she are hall but "I know he is alling in pain." 8/15, at 2:29 p.m. trained (TMA)-K said she used a hall but "I know what others in levels. The order was for ligram) 1 - 2 tablets every 3 she said if R61 had a pain ave 1 tablet. If he had a pain		809			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETSO	
		245227	B. WING			11	/18/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	312	(X6) COMPLETION DATE
F 309	pain control. She said in pain. RN-A stated a same pain scale and do not us any non pha Interventions and "we since survey started F control. She further staffecting his restlessor regular pain medication oxycodone 10 mg 3 till A progress note dated identified R61 was residentified R61 had hot PT-M stated therapy to scale. R61 rated his patherapy and did not aptherapy and did not appear to the last time pain, he said it was mot aware of any stanfacility, for pain managements.	ed he did not have adequate she has seen him grimace all staff should be using the they are not. She said they armacological pain should." RN-A stated R61 doesn't have good paln ated R61's pain may be ess so staff requested a con. His new pain order is for mes dally. If 10/24/15, at 1:11 a.m. stless and climbing out of men asked if he had pain I R61 said yes. If 7/15, at 9:05 a.m. PT-M cocks the nerve synapse. State of a Wong Baker pain pain as "a lot" on the Baker estarted physical therapy ing with his left leg, R61 ide hurt. PT-M did not ask a in medication before coply the TENS unit. If 5, at 7:55 a.m. RN-H a pain scale. She just asked in was mild, moderate or she asked R61 about his oderate. She sald she was dardized method in the gement assessments.	F	809			

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NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE, 2IP CODE 10 SAME OF PROVIDER OR SUPPLIER SAME OF SAME OF SUPPLIER SAME OF SUPPLIER SAME OF SAME OF SUPPLIER SAME OF SAME OF SUPPLIER SAME OF SAME OF SAME OF SUPPLIER SAME OF	1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUC A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
PASTHORE RESIDENCE & REHAB CTR PAGE DECIDENCE SUMMARY STATEMENT OF DEFICIENCIES EACH DECIDENCY MUST BE PRECEDED BY FULL PREFIX PREFIX PROVIDENCE PLAN OF CORRECTION BE CARD-CONTROLL BE PREFIX PROVIDENCE PLAN OF CORRECTION BE CARD-CONTROLL BE CAR			245227	<u> </u>			11/18/2015	
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FREFIX TAB REQULATORY OR LSt: IDENTIFYING INFORMATION) F 309 Continued From page 40 non-pharmocological interventions for pain on 11/17/15. "We saw that as a need for him." A facility polity titled: PAIN ASSESSMENT PROTOCOL reviewed 11/02, indicated, "It is the policy of Bayshore to provide for the optimum quality of life for every resident. Quality of Life includes individualized management of pain. Management of pain includes accurate assessment, pharmacological and non-pharmacological methods, and physical and psychosocial interventions." R 109 received hospice services, and the facility failed to provide coordination of care. Findings include: R 109's Admission Record identified diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 91/41/5, indicated R 109 had severe cognitive impairment, and required extensive to total assistance of staff with bed mobility, transfers, dressing, eating, mobility, personal hygiene, bathing and toleting. R 109 began receiving hospice services on 12/27/15, for end of life services due to the diagnosis of Alzheimer's disease. The most recent certification by the hospice agency was 9/17/15, and at that then it was determined he would receive skilled nursing services once a week for nine weeks, and nursing assistant (NA) services twice a week for nine weeks. On 11/12/15, at 1:27 p.m. nursing sessistant	BAYSHOR	RE RESIDENCE & REHA	B CTR					
non-pharmocological interventions for pain on 11/17/16. "We saw that as a need for him." A facility policy tilled: PAIN ASSESSMENT PROTOCOL reviewed 11/02, indicated. "It is the policy of Bayshore to provide for the optimum quality of life for every resident. Quality of Life includes Individualized management of pain. Management of pain includes accurate assessment, pharmacological and non-pharmacological methods, and physical and psychosocial interventions." R109 received hospice services, and the facility failed to provide coordination of care. Findings include: R109's Admission Record identified diagnoses that included Atzheimer's disease. The quarterly Minimum Data Set (MIOS) dated 9/14/15, indicated R109 had severe cognitive impairment, and required extensive to total assistance of staff with bed mobility, transfers, dressing, eating, mobility, personal hygiene, bathing and tolleting. R109 began receiving hospice services on 12/2/15, for end of fife services due to the diagnosis of Alzheimer's disease. The most recent certification by the hospice agency was 9/17/16, and at that time it was determined he would receive skilled nursing services once a week for nine weeks, and nursing assistant (NA) services twice a week for nine weeks, and nursing assistant	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
(NA)-K was interviewed, and stated the hospice NA came to the facility two or three times a week. NA-K stated they came at different times of the week, and different times of the day. NA-K stated	F 309	non-pharmocological 11/17/15. "We saw the A facility policy titled: PROTOCOL reviewed policy of Bayshore to quality of life for every includes Individualized Management of pain it assessment, pharmacon-pharmacological psychosocial interven R109 received hospid failed to provide coordinated to provide coordinated R109's Admission Rethat Included Alzheim Minimum Data Set (Mindicated R109 had stand required extensive with bed mobility, transmobility, personal byg R109 began receiving 12/2/15, for end of life diagnosis of Alzheime recent certification by 9/17/15, and at that till would receive skilled the week for nine weeks, services twice a week On 11/12/15, at 1:27 (NA)-K was interviewed NA came to the facility NA-K stated they came	interventions for pain on at as a need for him." PAIN ASSESMENT of 11/02, indicated. "It is the provide for the optimum of resident. Quality of Life of management of pain. Includes accurate cological and methods, and physical and tions." The services, and the facility dination of care. Cord identified diagnoses er's disease. The quarterly IDS) dated 9/14/15, evere cognitive impairment, at to total assistance of staff insfers, dressing, eating, giene, bathing and toileting. If hospice services on a services due to the pr's disease. The most the hospice agency was me it was determined he nursing services once a and nursing assistant (NA), for nine weeks. P. m. nursing assistant ed, and stated the hospice y two or three times a week, the at different times of the	F	309			

STATEMENT AND PLAN OF	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO A. BUILDING		ONSTRUCTION		TE SURVEY MEPLETED		
		245227	B. WING			1 1	1/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	,	•	1601	EET ADDRESS, CITY, STATE, ZIP CODE I ST LOUIS AVENUE LUTH, MN 55802		
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F 309	was going to be at the On 11/17/15, at 9:36 (RN)-C was interview NA schedule was "sp RN-G stated the facility prior to coming the hospice NA-s schedule hospice NA's have the facility does not keep the facility does not keep the facility does not keep the facility was aware schedule. The facility policy and Program dated 2/14, participates i the hospican of care between and resident/family weep the facility was aware schedule. R143 did not receive assessments of clinic corresponding physical According to his admitted on 7/13/15, plan for rehabilitation diagnosis report date diagnoses including rambulation (RBKA), of Admission orders for full code status; accutimes a day, call if resmilligrams/deciliter metalligrams/deciliter	are of when the hospice NA e facility to care for R109. a.m. registered nurse red, and stated the hospice oradic" and "they just come." ity does not have the le, and they do not call the g out. RN-G further stated e their own schedule, and now when they are coming. 7 a.m. the director of nursing ed and stated she assumed e of the hospice NA visit I procedure on Hospice directed when a resident sice program, a coordinated the facility, hospice agency ill be developed. timely and accurate al changes with ian updates as needed, ission face sheet, R143 was with a short term admission services. The resident of 7/13/15, Identified multiple light below the knee tiabetes and hypertension. R143 on 7/13/15, included check (blood sugar) four	F	309			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION€	(X3) DATE SURVEY COMPLETED		
		245227	B. WING		11/18/2015			
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1601	EET ADDRESS, CITY, STATE, ZIP CODE ST LOUIS AVENUE JUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC [DENTIFYING INFORMATION)	IC PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE		(X6) COMPLETION DATE
F 309	medications. R143's a pounds. R143's admit dated 7/20/15, identification assistance with calconfused. In addition, have a shortened life. On 7/14/15 at 12:22 p. Administration Record sugar (BS) of 297 mg 229 pounds. There with hyperglycemia (high Enot updated as ordere medications to assist management. No weight was obtain 7/16-17/15 R143 weight was no weight obtainer R143 weighed 231 powas obtained. On 7/21/18 a fax was physician identifying "tabs. There was no further was no f	week - call MD; and multiple admission weight was 233 ssion Minimum Data Set ed he needed extensive to ares and was moderately it identified R143 did not expectancy. a.m. the Medication of (MAR) identified a blood /dL R143's daily weight was as no assessment for as no assessment for ed. R143 was on no with blood sugar ed on 7/15/15. On cycle 230 pounds. There ed on 7/18/15. On 7/19/15 pounds. On 7/20/15 no weight sent to the primary many abnormal values for other assessment.	F	903				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION		E SURVŒY IPLETED
		246227	8. WING			1 11	/18/2015
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BAYSHOR	RE RESIDENCE & REHA	B CTR			SO1 ST LOUIS AVENUE IDLUTH, MN 55802		
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		1071					
F 309	Continued From page	43	l F3	309			
	. –	e daily weight had not been					
	obtained and there wa						
		dentified problem. At 2:00	i				
	-	of 260 mg/dL. The physician	1				
		there was no assessment	1				
		ere was no daily weight on	1				ll f
]	7/23/15. In addition or		1				
	R143's blood pressure		ļ				
		d blood pressures had	-				
		5/80. No other assessment					
	was completed and th						
	updated.	• •					
	Another fax was sent I	to the physician on 7/24/15					l i
	identifying on 7/19/15	R143's weight was 231.5					
[pounds and today was	s 242.3 pounds. It further					
	identified R143 had a	notable increase in edema					
	of legs, scrotum, hand	ls/arms. There was no					
	further assessment ob	stained or provided. On					
	7/24/15 the physician	ordered labs and					
	medication changes a	nd requested the facility fax		1			
		occult and orthostatic	!				
		ldition the physician ordered					
	a chest x-ray (CXR), a						
	(ECG). Although the o						!
- 1	-	transcribed until 7/25/15.					
		vork was no collected until					
- 1		RN-A on 11/17/15 at 1:10					
	p.m. revealed she did		l				
	transcription and imple						
	physician orders had t						
		entified "possible coronary					<u> </u>
		no evidence the physician					j
1		R dated 7/25/15 identified					
		pattern" which was faxed to					
		15. There was no dally				i	
		15. On 7/26/15 the occult					[
	stools came back posi						[
		to the physician. Although it					
	was stamped "Faxed"	the area for		I			

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	MENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245227	B. WING		11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEIPED BY FULL SCIDENTIFY:NG INFORMATION)	FD PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)			(XG) . GOMPLETION DATE
F 309	indicated there was no physician had been no results. On 7/26/15 Repounds for a total gala admission on 7/13/15 were completed and nower provided. On 7/29/15 at 2:00 at a caregiver answered back hurt wanted to be the caregiver was talk became cyanotic and was called and cardic was provided until padetermined to be explicated there had be R143's condition. RN not updated with the lowas being monitored stated the facility had hyper/hypoglycemia experience initiated here. Recalled the physician weights but "just not experience also stated it was that there was nothing further orders had the RN-A stated she remaware of "some of the was updated on all of that as she reviewed "gone forward and up	blank. Interview with I)-A on 11/15 at 1:10 p.m. Io indication in the record the otified of the occult stool 143's weight was 258.5 in of pounds 25 since. No further assessments no further physician updates in the call light. He stated his e turned on his side. While sing to the resident he unresponsive. A code blue apulmonary resuscitation ramedics arrived. R143 was ired at 3:05 a.m. In 11/17/15 at 1:10 p.m. seen no assessments of A stated the physician was blood sugars and nothing for those changes. RN-A begun monitoring for every shift but that had not N-A further stated she being updated on some every day." RN-A stated she e we notified him." However, "unusual and suspicious"	F3	1. No residents were affected by the deficient practice of failing to coord; care with Hospice. 2. All Hospice residents may be affer the alleged deficient practice. 3. An interdisciplinary meeting was with Hospice on 12-9-2015 regarding coordination of care. Meetings are scheduled every two weeks. Hospice providing schedules of the nursing a visits every Monday.	nate eted by neld is	

	OF DEFICIENCIES CORRECTION					(XS) DATE SURVEY COMPLETED	
		245227	B. WING_			11/	18/2015
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR (X4) ID PREFEX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			Io PREFIX	16 D	TREST ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		cross-referenced to the appropriate deficiency) 4. Minutes of the biweekly meeting w.		DATE
	emergency room had from the physician. Interview with the resi 11/17/15 at 2:45 p.m. R143 on 7/24/15. He I weight gain and he su abdominal cavity) and indicated R143 had m the facility had not red the time of this reside the results received fr 7/24/15, "things looke R143 had the fluid over pancytopenia (deficient components of the bload platelets). P-A we R143 had bone marror required very aggress the Issues were follow treatment. When interviewed on director of nursing (DC a quality review procedeath records. The DC reviewed a death recondifications but "since been a question of wright for the procedeath records and the procede in the proc	dents physician (P)-A on indicated he had seen had been updated in R143's espected ascites (fluid in the fluid overload, P-A further ultiple co-morbidities and seived a lot of information at int's admission. Based on om the tests ordered on diterible," going on to say erload, ascites, and ney of all three cellular and red cells, white cells, and one to say he believed wissues that would have live tests to determine what red by very aggressive 11/18/15 at 11:36 a.m. the DN) stated when she ard she reviewed for a live been here there hasn't tongful death." The DON majority of dea(hs were and no physician had ever death records weren't stated R143 was refusing ult to get him to cooperate.	F3	609	4. Minutes of the biweekly meeting will hospice will be reviewed at the month QAPI committee to assure coordinatio care is continuing. 5. The Director of Nursing/designee is responsible. I Resident # 143 expired 7-29-2015. 2. All residents have the potential to be affected by the alleged deficient praction of the providing services as directed by a physician. 4. The facility will audit two (2) reside charts per week times twelve weeks to monitor license staff are providing service as directed by a physician. Any negative courrence will be immediately report the Director of Nursing. These audits will make a recommendation as to the to continue to monitor that the license are providing services as directed by the Physician. 5. The Director of Nursing /designee will be incompleted by the physician. 5. The Director of Nursing /designee will physician date of 12-31-2015	of n of ce, ce, ce, co will three ins, ce need staff ie	
t t	PREVENT/HEAL PRE		F 3	14			
	Based on the compret	nensive assessment of a					

NAME OF PROMOBER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE 2IP CODE 1697 ST LOUIS AVENUE DULUTH, MN 55802 DULUTH, MN 55802		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
### PAYSHORE RESIDENCE & REHAB CTR PAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802				B. WING				11/18/2015	
F 314 Continued From page 48 resident, the facility must ensure that a resident who enters the facility must ensure that a resident who enters the facility must ensure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services to prevent and promote healing of pressure ulcers for 2 of 4 residents (R22 and R152) reviewed for pressure ulcers. Findings Include: R22's quarterly Minimum Data Set (MDS) dated 9725/15, indicated R22 had severe cognitive impairments and required extensive assistance with transfers. The MDS included diagnoses of diabetes mellitus, hemiparesis and cerebral palsy. The MDS indicated R22 had a stage 2 pressure ulcer (Partial thickness loss of demise presenting as a shallow open ulcer with a red pink wound bed, without slough), that was unhealed and was not present at the time of the previous assessment. The skin Care Area Assessment (CAA) dated	BAYSHOR (X4) ID	RE RESIDENCE & REHA	B CTR ATEMENT OF DEFICIENCIES		16 Di	601 ST LOUIS AVENUE DULUTH, MN 55802 PROVIDER'S PLAN OF CORRE			
F 314 Continued From page 48 resident, the facility mithout pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services to prevent and promote healing of pressure ulcers for 2 of 4 residents (R22 and R152) reviewed for pressure ulcers. Findings Include: R22's quarterly Minimum Data Set (MDS) dated 9725/15, indicated R22 had severe cognitive impairments and required extensive assistance with transfers. The MDS indicated R22 had a stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), that was unhealed and was not present at the time of the previous assessment. The skin Care Area Assessment (CAA) dated				TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
developing pressure ulcers due to impaired program. mobility, incontinence, needed extensive 5. The Director of assistance with positioning and had a history of healed pressure ulcers. Nursing/designee with	F 314	resident, the facility method enters the facility does not develop presindividual's clinical conthey were unavoidable pressure sores received services to promote he prevent new sores from this REQUIREMENT by: Based on observation review the facility failed services to prevent and pressure ulicers for 2 of R152) reviewed for pressure ulicers for 2 of R152). The MDS indicated R21 impairments and requivith bed mobility and transfers. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy, incontinence assistance with position more assistance with position menters and resident mellitus.	sust ensure that a resident without pressure sores sores unless the addition demonstrates that a resident having es necessary treatment and ealing, prevent infection and mideveloping. is not met as evidenced in interview and document ad to provide care and ad promote healing of of 4 residents (R22 and essure ulcers. In Data Set (MDS) dated a stage 2 total assistance with included diagnoses of interview and cerebral ated R22 had a stage 2 thickness loss of dermis ow open ulcer with a red out slough), that was a time present at the time of the sessesment (CAA) dated the R22 was at risk for alicers due to impaired, needed extensive and particular and had a history of	F	314	WCC nurse, the would decreased in size, an free of signs and syminfection. Resident his of refusing reposition results in occasional Staff continue to encrepositioning. 2. All residents would be considered at risk for deficient practice. 3. The Nursing staff we reeducated on skin with focus on prevention development of would be considered at risk for deficient practice. 4. Nurse nurses are plus laminated card underesidents with instruing return to nurse and lange on the Unit to repositioning. 4. Nurse managers will logs and report to the QAPI committee. Aft months the QAPI committee as to the need to commonitor the reposition program. 5. The Director of	nd hand remark his his his his his courage of alleger his	a sto	

ANAME OF PROVUDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR SUBMANY STATUS OF THE PROPERTY OF DEPT STATE OF DEPT STATE OF DODE 1649 ST. LOUIS AVENUE DULLTH, MN \$5802 FOR SUBMANY STATUSHY OF DEPT STATE OF DEP STATE OF DEPT STATE OF DEP STATE OF DEPT STATE OF DEP STATE OF DEPT STATE OF DEP STATE OF DEP STATE OF DEPT STATE OF DEP STATE OF DEP STATE OF DEP STATE O		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1		CONSTRUCTION		E SURVEY PLETED
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FREFIX TAG REGULATORY OR ISC DIGHTEVING INFORMATION) F 314 Continued From page 47 R22's care plan dated 8/22/15, indicated the resident had a pressure ulcer to the right ischium (forms the lower and back part of the hip bone), interventions included: - administer medications as ordered - administer medications as ordered and monitor for effectiveness weekly skin assessment, Braden [assessment for predicating pressure ulcer risk] and fissue tolerance [assessment for repositioning schedule] quarterly and as needed (PFN)] - monitor nutritional status, serve diet as ordered - moisturizer applied twice daily and PRN to skin, do not massage over bony prominences - weight bearing assist from staff for significant repositioning every two hours and PRN in wheelchair and bed, resident has a history of refusing, - requires an alternating air mattress on his bed and cushion in wheelchair. R22's medical record lacked evidence of a comprehensive skin risk assessment, to be done quarterly and PRN por the care plan. R22's medical record lacked a Tissue Tolerance Assessment, to be done quarterly and PRN por the care plan. R22's medical record lacked any assessment related to tissue profusion. R22's medical record lacked evidence of consistent weekly skin assessments since June of				,	16	601 ST LOUIS AVENUE		
F 314 R22's care plan dated 9/22/15, indicated the resident had a pressure ulcer to the right ischium (forms the lower and back part of the hip bone), interventions included: - administer realications as ordered - administer treatments as ordered and monitor for effectivenese weekly skin assessment, Braden [assessment for predicating pressure ulcer risk] and itsue tolerance [assessment for a needed [PRN] - monitor nutritional status, serve diet as ordered - moisturizer applied twice daily and PRN to skin, do not massage over bony prominences - weight bearing assist from staff for significant repositioning every two hours and PRN in wheelchair and bed, resident has a flistory of refusing - requires an alternating air mattress on his bed and oushion in wheelchair. R22's medical record lacked evidence of a comprehensive skin risk assessment, to be done quarterly and PRN per the care plan. R22's medical record lacked a 7:22/15, indicated R22 was at a low risk for developing pressure ulcers. R22's medical record lacked and PRN per the care plan. R22's medical record lacked any assessment, to be done quarterly and PRN per the care plan. The medical record lacked any assessments related to tissue profusion. R22's medical record lacked evidence of consistent weekly skin assessments since June of	PREFIX	(EACH DEFICIENC)	A WINSJ, BE SWECEDED BA LITT	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
LINUTE LINE TOLICULUITA EVID DECARRIGADES SITAS	F 314	R22's care plan dated resident had a pressur ischium (forms the low hip bone), intervention - administer medicatic - administer treatment for effectiveness. - weekly skin assessmen changes reported to tit - skin risk assessmen predicating pressure utolerance [assessmen schedule] quarterly ar - monitor nutritional stirmoisturizer applied to do not massage over - weight bearing assis significant repositionin PRN in wheelchair and bistory of refusing. - requires an alternational comprehensive skin rid done quarterly and PR R22's medical record comprehensive skin rid done quarterly and PR R22's medical record for R2	I 9/22/15, indicated the pre ulcer to the right wer and back part of the pre included: ons as ordered and monitor ment by a nurse, with the MD to the present for ulcer risk] and tissue at for repositioning and as needed [PRN] tatus, serve diet as ordered who prominences at from staff for any prominences at from staff for any every two hours and died, resident has a lacked evidence of a lacked evidence of a lacked evidence of a lacked evidence of a lacked a Tissue Tolerance e quarterly and PRN per lical record lacked any itssue profusion.	F3	314	be responsible. Completion date of		

	OF PEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		245227	B. WING			11/18/2015
	ROVIDER DR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS, CITY, STATE, ZIP CO 1601 ST LOUIS AVENUE DULUTH, MN 55802)DE	
(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 CO ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	NISHOULD BE EAPPROPRATE	(X5) COMPLETION DATE
F 314	stage 2 pressure ulce and measured 4.5 ce depth of less than 0.1 90% red with 10% ye appearance. No exud tissue intact, pink and foam border dressing orders. Interventions pressure mattress an Skin/Wound Noted ch 11/10/15 with require. The medical record lare-assessment of the ulcer interventions or the current pressure to the regarding the current dressing not staying i responded and order dressing to be change. Review of the medical that the wound or drewere observed daily. When interviewed on nursing assistant (NA be repositioned every assistance to repositional alternating air pressure.)	atted 7/1/15, 8/19/15, 15. If recorded indicated the ar was discovered on 9/2/15, ntimeters (cm) x 0.5 cm x a cm. "Wound base was llow tissue and was moist in ate, no odor. Surrounding I blanched. Writer applied and will seek physician in place include alternating discovered wheel chair cushion." Interest weekly from 9/22/15-discovered wound desciptions. Incked any evidence of a residents current pressure an analysis to the cause of ulcer. Inchest of a foam in place. The physician ed a thin hydrocolloid ed every 3 days. If record lacked evidence ssing with surrounding skin 11/17/15, at 7:14 a.m. 1-10-1-17/15, at 7:14 a.m.	F :	314		

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP CO 1601 ST LOUIS AVENUE DULUTH, MN 55802	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECROED BY FULL LSG IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF GO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 314	When interviewed on registered nurse (RN) weekly measuring and wounds in the facility. developed a stage 2 pischium on 9/22/15, a improved. RN-B desc quarterly Braden Scal observation on reside Tissue Tolerance assinever seen that type of in the facility. RN-B of documentation of an adeveloped a pressure new interventions had RN-B stated that she therapy but after revise could not provide a dainy therapy R22 had stated that residents a repositioning every 2 lis required to be less, provide documentation assessed for an every schedule. During the the weekly skin obserweekly as care planneall wounds are discustoss and skin team medical record related to the weight led discussions.	the development of the fr. 11/17/15, at 2:19 a.m. B stated she does the diassessments of the RN-B verified R22 pressure ulcer to his right and the pressure ulcer has ribed that the nurses do a le and weekly skin ants, but they do not use a ressment and added she has professessment since starting outd not provide analysis of why R22 had a ulcer. When asked what a been Implemented for R22 thought he was seen by ewing the medical record ate or information regarding received. RN-B further are always care planned for hours unless the frequency RN-B could not state or no how R22 was a 2 hour repositioning interview RN-B verified that wations were not completed and for RN-B also stated that seed in the weekly weight	F	314		

245227	B. WING			
Z45221			11/18/201	15
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) IO SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOLD CROSS-REFERENCED TO THE APPROPRIES OF THE A	LD BE COMP	X5) R,ETK)N ATE
assessing for appropriate individualized repositioning schedules. RN-H stated the facility gets instructions on admission from the hospital on the repositioning frequency a resident needs or from physical or occupational therapy. When interviewed on 11/18/15, at 7:43 a.m. the occupational therapist (OT) stated R22 was seen from 7/30/15 through 8/21/15 prior to the development of the current pressure ulcer. The OT stated R22 was assessed for wheelchalr positioning to aid in independent eating. The OT stated R22 had a cushion removed from his wheelchair that had been placed on top of his roho cushion and they adjusted the back of his wheelchair to decrease leaning. The OT stated she was made aware of R22's development of a stage 2 pressure ulcer but did not pick him up for therapy as there isn't anything more therapy could do for R22. The OT further stated that the therapy department can do pressure mapping if requested and ordered but they do not do routine screening for tissue profusion and added that it is a nursing assessment. When interviewed on 11/18/15, at 8:23 a.m. RN-C replied "That's a really good question," when asked how a resident is assessed for appropriate repositioning schedules. RN-C reviewed R22's record and confirmed that R22's record lacked a comprehensive risk assessment and tissue tolerance assessment. RN-B stated she was taught to use the Braden Scale, then confirmed the Braden is not a comprehensive risk assessment. On 11/18/15, at 9:35 a.m. R22's wound was observed to be a stage 2 pressure ulcer to the	F-	314		

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	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION		SURVEY PLETED
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	в стп	·	1601	EET ADDRESS, CITY, STATE, ZIP CODE I ST LOUIS AVENUE LUTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	odor. The edges of th surrounding tissue bla (RN)-B stated the me changed since 11/17/ rounds. The wound had the me changed since 11/17/ rounds. The wound had the me compared on director of nursing (Down and that the nurses updetermine an approprior residents. The DO was repositioned time plan. The DON stated specific tool to assess DON further stated we should be completed. The undated facility Sindicated assessment are completed upon a readmission and daily patient/residents. Requested a policy or ulcers and the facility. R152 did not receive a few development and pulcers. According to the R152 was admitted on neuroendoctine carcin obstruction and significare Area Assessment.	peefy red, without slough or se wound were intact and the anched. Registered nurse asurements had not 15 when she did her weekly ad measured 2.4 cm x 1.2 han 0.1 cm. 11/18/15, at 10:20 a.m. the DN) stated that all residents is repositioning schedule did repositioning schedule. If you according to his care of the facility does not use a stor tissue profusion. The peekly skin observations and documented. It was a the prevention of pressure at the prevention of pressure.		314			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	·········	16	TREET ADDRESS, CATY, STATE, ZIP CODE 801 ST LOURS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XB) COMPLETION DATE
F 314	identified no individual but did identify it would and policies. A progress note dated had mepiplex on his deadmission for "prevent Braden skin risk asset R152 to be at low risk physician progress no skin breakdown. A physician order dat mepiplex (foam dress dressing every 4-7 dat float heels and remind 2 hours. There was no record to correspond physician's order. On directed staff to place absorbent all in one with moisture barrier on the breakdown on the right progress note identification in the right buttock meat 2 cm. A weekly skin at 6/20/15, identified the skin was for skin issues the we broken at coccyx" with There was no further R152. R152 expired on 11/17/15, at 12:58 (RN)-A stated there we documentation availation availation availation availation availation availation absence of the complete results	dated as initiated on 6/5/15, dized interventions for R152 d follow facility protocols d 5/28/15 revealed R152 exceys at the time of stative measures." The sament of 5/28/15, identified for skin breakdown. A site dated 6/2/15, indicated ed 6/17/15, identified ing) to the coccyx - change may and as needed (PRN) - di [R152] to reposition every of documentation in the with the need for the new 6/19/15 a physician order an Optifoam dressing (an evound dressing with a elecution of the skin into buttock. A 6/19/15, ed skin breakdown noted on suring 2 centimeter (cm) by assessment completed into the first of the fi	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLFA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
	245227	B. WING		11	/18/2015
PRÉFIX (EACH DEFIGIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	:	(X5) COMPLETION
F 314 Continued From pal Improve their skin of take specialized workidentified the facility policy wassessments and uneeded. RN-A state finalized for R152 y. On 11/18/15 at 8:33 (DON) stated she in she believed R152 DON further stated for "protection" due break down. She climated she would break down. She climated she would break documentation a we have on the work be "all the document of the documents, the Information provide 483.25(h) FREE OF HAZARDS/SUPER. The facility must enemylment remains as is possible; and adequate supervisite prevent accidents.	ge 53 are and had one of the nurses und care training. RN-A as to complete weekly skin pdate the practitioners as dithe care plan hadn't been at. if a.m. the director of nursing realled R152, The DON stated frever really opened up." The the dressings in place were to R152's high risk for skin arified that dressings are used aplice residents. The DON we to look at R152's record additional information. On and the DON provided copies and stated it was "everything ands." The DON believed it to tation we need." Upon review there was no additional information. ACCIDENT		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 3. Nurse Managers will audit weekly the skin checks are completed timely for the months. Observations rounds will be conducted by the nurse managers and development to monitor that turning schedules are being performed per the resident's plan of care. 4. Audit outcomes will be discussed at for three months to determine if further education is needed. 5. The Director of Nursing/designed was responsible. Completion date of 12-31-2015.	bat liree staff	
by: Based on observat	оп, interview, and document				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER.	1	(X2) MULTIPLE CONSTRUCTION (A. BUILDING			(X3) DATE SURVEY COMPLETSO	
		245227	B. WING			11/	18/2015	
	(EACH DEFICIENC	B CTR ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1601 DUI	EET ADDRESS, CITY, STATE, ZIP CODE 1 ST LOUIS AVENUE LUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 1. Resident #42 owns his ow	TE :	(XS) COMPLETION DATE	
F 323	assessments were conterventions were deminimize the risk for f (R61) reviewed for fail evaluate the causativities of the causativities	ed to ensure comprehensive impleted and individualized veloped and implemented to alls for 1 of 2 residents is. The facility failed to a factors of resident falls to a swere appropriate. The sed in an immediate jeopardy, fracture) for R61. In alled to ensure side ralls cured for 1 of 1 residents de rails. The design on 10/22/15, for the hospital following a body and hematoma. R61 cant change in condition dization. Upon return, the series R61's multiple changes der to assist in developing ized interventions to angoing falls. The director of confided of the immediate on 11/12/15, at 6:23 p.m. rady was removed on an but noncompliance for scope and severity of a G. I harm that was not use to fractured hip.	·F	323	bed. Resident #42 was interviewed regarding the of the side ralls. Resident unable to turn self or reasside rails due to disease a severe upper extremity contractures. Resident stake only uses the side rails one side of the bed and owith staff present assisting with turns. The opposite rail was removed, which eliminates the safety issue Resident #61 does not has side rail — only an assist be with no history of loosenical. The bariatric beds have be identified with side rails a would have the potential affected, however there is never been an issue identified with our current side rails becoming loose.	e use is ch nd ates on nly g side e. ve a ar, ng. been and to be has		

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1, ;	PLE CONSTRUCTION G	1''	TE SURVEY MPLETED
		245227	B. WING_		1 4	1/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 56802		171012013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST 88 PRECEDED BY FULL SC IDENTIFYING INFORMAYION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 323	individualized interver the risk for ongoing fa R61's quarterly Minim 9/8/15, identified he windependent when arrithe hallway. On 9/21/hospital with a subdurback following a fall. I hospital on 10/22/15, indicated R61 was set and had no behavior pidentified R61 required one staff for activities MDS also identified R1 transfers was not steastabilize without assist R61 had pain, receive was at risk of falls, and injury. R61's Fall Care Area / 11/2/15, indicated R61 with a history of falls in not address individualitheir efficacy or the need they were checklists or comprehensively assist appropriate interventio data gathered indicate falls, had decreased or devices, and had multiple R61's care plan initiate he was a high risk for the supplemental intervention of the reference of the plan initiate he was a high risk for the supplemental intervention of the reference of the plan initiate he was a high risk for the results of the reference of the plan initiate he was a high risk for the reference of the plan initiate he was a high risk for the reference of the plan initiate he was a high risk for the reference of the plan initiate he was a high risk for the plan in the	need for additions to the ntions to assist in minimizing ills. um Data Set (MDS) dated as cognitively intact and abulating in his room and in 15 he was admitted to the all hematoma and fractured R61 returned from the R61's MDS dated 10/29/15, werely cognitively impaired problems. The MDS further diextensive assistance of of daily living (ADLs). The 61's balance during dy, but he was able to lance. The MDS identified dipain medication daily, die had a history of fails with Assessment (CAA) dated I was at high risk for falls in the past. The Fall CAA didized interventions in place, and for changes. Risk Assessments ally on 11/12/15, however, containing data which did not less R61's fall risk to ensure ans were implemented. The died R61 was at a high risk for coordination, used assistive	F 32	23		

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	OF DEFICIENCIES F CORRECTION	(X†) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDS	TIPLE CONSTRUCTION NO	_	(X3) DATE SURVEY COMPLETED
		245227	B. WING.			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REH A			STREET ADDRESS, CITY 1801 ST LOUIS AVENU DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATRMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENT:FYING INFORMATION)	ID PREFIX TAG	(EACH CORI	K'S PLAN OF GORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)	
F 323	multiple falls with inju "The resident will be the review date." R61's care plan date following intervention encourage use, promensure appropriate for ordered, activities for alarm in bed and who alarm in bed, transfel and back brace. The 11/9/15, following mu motion sensor alarm implemented. Observation on 11/9/ R61 lying in bed with table. The overbed to feet away from R61's was turned off. The I him. Registered nurs motion alarm was tur out of reach. RN-M to and identified it was a changed the batteries alarm to work. On 11/9/15, at 5:20 p found turned off. RN tray and left the room on. When asked to we turned off she stated the alarm was a prob sounding "so we don On 11/9/15, at 6:20 p	continence, diabetes and ries. The identified goal was free of minor injury through did 11/9/15, identified the scall light within reach and apt response to call lights, betwear in use, PT as diversion/distraction, TAB eleichair (w/c), pressure with assist of 1, gait belt care plan was revised on altiple observations of a not being appropriately distraction alarm the motion alarm the motion alarm the motion alarm the motion alarm on the functioning. RN-M is and was able to get the larm the motion alarm was and was able to get the larm the motion alarm was alternative the motion alarm was and was able to get the larm the motion alarm was alternative the motion alarm was it was. RN-A further stated alem as it was always the motion alarm was it was always the motion alarm was alternative the motion alarm was it was always the motion alarm was it was always the motion alarm was the motion alarm was alternative the motion alarm was it was always the motion alarm was it was always the motion alarm was the motion alarm the motion alarm the motion alarm the	F	323		

Facility 1D 00689

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION		E ŞURVEY PLETED
		245227	B. WING.			1 11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			160	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(FACH DEPICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIA DEFIGIENCY)		(X5) COMPLETION DATE
	2:13 a.m. identified the fall. R61 stated he was his room and tripped that his head and also a shoulder pain. Another progress note p.m. identified R61 has sitting on the he hit his head. R61 shoulder ball head on the doorknot was not utilizing his were recomplained of dispain on palpation to be was dizzy, his legs gas call physician directed neurological changes or back. On 9/22/15 at to complained of ringing headache. R61 had in unable to roll or sit up blood pressure dropped 53. R61 was sent to the was admitted with a sheed) and fractured by 10/22/15, at 1:47 p.m. form the hospital. On 10/24/15, at 1:11 administration note incand climbing out of be up walking alone goin alarm was off and did	ress note dated 8/22/15, at e resident self reported a swalking around the bed in on the bed. R61 stated he complained of slight e dated 9/21/15, at 3:51 and fallen and hit his head. It is easier the was in the land hit the back of his er of the bathroom door. R61 alker at the time of the fall. It is easier to monitor for any and increased pain to head to 7:15 a.m. R61 continueding in ears, dizziness, and a coreased back pain and was in bed or ambulate. His east to 94/53 and pulse was ne emergency room and ubdural hematoma (brain back. A progress note dated indicated R61 returned. a.m. a medication dicated R61 was restless and multiple times. R61 was g through his closet. The not sound.	F	323	DETIGENOTY		
	_	10/25/15, at 10:59 p.m. neurological checks due to					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION (X3) UILDING			SURVEY PLETED	
		245227	B. WING				11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16D	EET ADDRESS, CITY, STATE, ZIP CODE 1 ST LOUIS AVENUE LUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCHDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BR		(XS) COMPLETION DATE
F 323	hallway looking for his on his feet. He had 3 he had one alarm tuck afarm wrapped up in a atarm did not sound. A progress note dated identified R61 was formiddle of the room. A alarms and a motion athe alarms sounded. The nursing progress 9:22 a.m. indicated R1 weight on his right low was complaining of pacomplained on 10/30/significant pain when was sent to the emergadmitted with a right afarmur) fracture. R61 manure fracture. On 11/12/15, at 2:45 the surveyor to be sittly wheelchalr. R61 was closed. No alarms we discovered on his foot to the room, LPN-A and alarms sounding a within reach. An incident note dated indicated R61 slid out being held onto by R1 and was not quite on the surveyor to the sittle with the surveyor to be sittle wheelchalr. R61 was closed. No alarms we discovered on his foot to the room, LPN-A and alarms sounding a within reach.	R61 was up walking in the stogs. R61 was unsteady atarms in ptace, however, ked in his pants pocket, one a blanket, and the third of 10/29/15, at 6:18 p.m. and on the floor in the lithough R61 had 2 TAB afarm on the floor, none of note dated 10/31/15, at 6:1 was unable to bear ver extremity (RLE) and ain. Staff reported R61 15 as well. R61 had up in the wheelchair. R61	F	323				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER;	1		CONSTRUCTION	(X3) DATE COME	SURVEY LETED
	:	245227	B. WING,			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		10	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE IULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCILLENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		(X5) COMPLETION DATE
	practical nurse (LPN) the mechanical lift. R61's falls were review nursing (DON) on 11/DON indicated the fall the recliner with no injury was independent with there were no specific that time. The DON stated the number R61 fell in his bowent to the side of the self-reported the fall. It walker and there was reported he hit the barbathroom door knob. Sure when the TAB all Other interventions in physical therapy (PT) reach, appropriate for assist of one, gail belt The DON indicated with 10:30 a.m. he was four roommate's bed. The DON stated R61 had and he was confused, motion sensor alarm with DON further stated be on 10/29/15, alarms with interventions. The DO "trying to manage his restlessness may hav difficulty expressing particular was confused and the control of the pool	nair. RN-B and licensed A returned R61 to bed with wed with the director of 12/15, at 3:58 p.m. and the l of 8/22/15, was a slip off iury. The DON stated R61 ambulation at that time so interventions for falls at mext fall was on 9/21/15, athroom, got himself up and bed. The DON said R61 R61 was not using his no obvious injury. R61 ck of his head on the The DON stated she wasn't arm was placed on R61. place at that time included: to evaluate, call light within but wear, and transfer with the, and back brace on. then R61 fell on 10/25/15, at and crawling toward his fall was unwitnessed. The gripper socks on at the time the DON Identified a was added at that time. The alween this fall and the one were the only additional the also indicated staff was pain" as they felt the the been related to his ain.		323			
	The DON stated R61	also fell on 10/29/15, at					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŧ		ONESRUCTION	(X3) DATE ŞURVEY COMPLETED	
		245227	B. WING.			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1601	EET ADDRESS, CXTY, STATE, ZIP CODE ST LOUIS AVENUE .UTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DRFIGIENCY)		DATE COMPLETION DATE
F 323	when R61 was found. wrapped up in his bla were no new interven stated she did not bel result of the fall becauproblem until 2 days at The DON went on to the pedais of his when not believe that was a slipped off the chair. It explain how R61 slipp When asked about reinterventions, the DOI over to answer specifications. A requestion of the pressurasked for a pharmack medications. A requestion a reassessment. Fithe alarms not sound in not aware there had be about an interdisciplinassessment of the fall cause of the falls, the interventions and idermay be appropriate to falls, both the DON and done that. An interview on 11/9/therapist (PT)-A ident 10/22/15, to 10/30/15 current. PT-A said where the control of the pressurations and identity of the poon and the poon a	alarms were sounding. The TAB alarm was nket. The DON said there tions at that time. The DON ieve the hip fracture was a use R61 did not report the after the fall. say when R61 was found on elchair on 11/12/15, she did if all. The DON stated R61 However, the DON could not bed out of the wheelchair. viewing the specific fall N invited the nurse manager ic questions. 11/12/15, incident she d alarm in R61's wheelchair sheet) on the top and e pad. RN-A also said they st review of R61's st was also sent to therapy RN-A was informed about ing and indicated she was been issues. When asked lary team comprehensive lis to determine the root	F	23			

	OF DEFICIENCIÉS CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	1		CONSTRUCTION		SURVEY PLETED
		245227	a. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	BCTR		16	TREET AUDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFFX YAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	١	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(Xb) COMPLETION DATE
	came back from the h subdural hematoma in all three disciplines (p speech) to assess and staff saw R61 for eigh ambulate him but he distated R61 had a lot of fracture. PT-A stated it services was on 11/3/hospital with the aceta another fall. R61's ord as tolerated. Therapy (Transcutaneous Electronic for his pain. PT-A a 10/f0 and staff coult expressions when he expressions when he expressions when he expression on 11/6/15, said they changed his because it didn't fit him kept sliding off the leg they put a calf pad in particular put a calf pad in pat pat put a calf pad in pat put a calf pad in pat	ospital following his in 10/15, he had orders for hysical, occupational, and ditreat. PT-A stated therapy it days. Staff attempted to could not ambulate. PT-A of pain due to his back the next request for lherapy 15, after returning from the abulum fracture from lers were for weight bearing staff utilized an TENS strical Nerve Stimulation) stated R61 rated his pain at ditell by R61's facial was in pain. Wide on 11/12/15, at 12:45 sical therapy did an apost fall with injury, she wheelchair at that time in well. PT-A was aware leg of the wheelchair. She said place that morning. E. J. on 11/13/15, updated in a fall care plan included the at However, the cobserved to be any, or staff were not the changes. The resident's needs, ent unattended when up in post falls and attempt to	F	323			

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-	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	REET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE BLUTH, MN 55802			
(X4) ID PREF2X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PROCEDED BY FULL LSC IDENTSFYING INFORMATION)	(D PREFD TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(XS) COMPLETION DATE	
F 323	Educate resident/fam Provide diversion and music, socials and sp Offer a snack (food at states he's hungry or effectiveness. PT evaluate and treat The resident uses TA and w/c. Pressure alson top and bottom of During an interview of trained medication at had one pressure alarm in his. An observation on 11 was sitting by the nurwith his TAB alarm or nearby activities programmer to the documentation identification and the documentation identification and the documentation identification and the documentation identification and changes to Round the documentation identification and changes to Round the documentation identification and changes to Round the other hall but, "I keyelling in pain."	ential causes if possible. illy caregivers/IDT I distraction such as news, ecial events. Indid drink) when restless, unable to sleep and monitor It as ordered. B electronic alarm in bed farm in bed and w/c. Dycem pressure mat in w/c. In 11/13/15, at 8:17 a.m. esistant (TMA)-K stated R61 Im in his chair and a bed. I/13/15, at 10:00 a.m. R61 ses station in the hallway In but not in attendance at the Iram. I/13/15, at 11:28 a.m. I/13/15, at 11:28 a.m. I/13/15, at 11:28 a.m. I/13/15, at 10:00 a.m. R61 ses station in the hallway In but not in attendance at the I/13/15, at 11:28 a.m. I/13	F:	323				

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	1 ' '	TPLE CONSTRUCTION VG	_		E SURVEY IPLETED
		246227	B. WING		,	11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, C 1601 ST LOUIS AVE DULUTH, MN 5580			
(X4) ID PREFIX TAG	(EVCH DELICIENC.	ATEMENT OF DEFICIENCIES Y MUST RE PRECEDED BY FULL LSG IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIA DEFIGIENCY)		(X6) COMPLETION DATE
F 323	has alarms in his chainot aware of any new yesterday. An interview on 11/13 family member (FM)-H September he slipped R61 told FM-K he waget help. FM-K stated R61's mind was clear. An interview on 11/16 stated, "I didn't know the has a back brace and his back brace any changes in his pladays NA-G was aware chair and his bed. During an interview with p.m. stated the change included: alarms in the when up he needs to be	on fall precautions, so he ir and a TAB alarm. She was plan of care since /15, at 11:06 a.m. with Cindicated when R61 fell in the bathroom. as tired of waiting so long to diprior to his head injury, /16 at 3:43 p.m. NA-G he fell. He is in a lot of pain, and is a full mechanical lift." he hadn't been informed of an of care in the last couple a he had alarms on his h RN-D on 11/16/15, at 3:47 in R61's plan of care wheelchair and bed, and e ln the dining room or by	F:	123			
	wheelchair and a press was education for staff signed after receiving the An interview with RN-A stated staff placed a prealarm in his bed and while fit unattended while in engaged in activities. TR61's medications and well. The physician order	on 11/16/15, at 4:07 p.m. essure pad and and a TAB neelchair. R61 was not to be the wheelchair. He is to be he pharmacist reviewed the medical doctor will as ered a scheduled a pain er stated she has seen R61 eed he did not have					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SULAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING (X3) MULTIPLE CONSTRUCTION (X3) DATE SULAN OF CORRECTION (X5) DATE S		E SURVEY PLETED				
		245227	B. WING		101000	11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		,	11	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE IULUTH, MN 56802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(D PREFI) TAQ	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X9) GOMALEHON BATE
F 323	staff should be using they are not. She sald pharmacological pain should." RN-A stated doesn't have good pa R61's pain may be af staff requested a regunew pain order is for daily. Interview on 11/16/15 indicated they change falls to include a weel PT, to review all high committee will review are in place and all of fall risks. An interview on 11/13/15. It hings independently, planned 1:1's. The testall meetings and she An observation on 11 was doing therapy for about his wheelchair agreed and said "the tengthened a little." That that time. An interview on 11/17	the same pain scale and the same pain scale and they do not us any non interventions and "we since survey started R61 in control. She further stated fecting his restlessness so that pain medication. His oxycodone 10 mg 3 times oxycodone for oxycodone including the medical for oxycodone including the said oxycodone oxycodone including the oxycodone		323			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NO	(X3)	DATE SURVEY COMPLETED
		245227	B, WING_			11/18/2015
	ROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF PEFICIFINGIES CY MUST BE PRECEDED BY FULL R I.SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD:BE	(XS) COMPLETION DATE
F 323	the pharmacist and recommendations replace. An interview on 11/2 said she had accider she started but not with the started but not with the started but not with the immediate jeopa was removed on 11/2 implemented the foliominimize the risk of the noncompliance remassive for the property jevel of G - in level, which indicated immediate jeopardy. Actions taken to remain verified through observed review were a 1. Comprehensive for completed. 2. Physician orders for (BMP) and urinallysis 3. R61 was not left a observations. 4. R61 was included sessions. 5. Alarms were in placed. 6. NA care sheets with the NAs. 7. Care plan was up 8. The medication a records were updated 9. The pharmacist an recommendations were	7/15, at 12:24 p.m. RN-A said medical doctor's egarding R61's falls were in 17/15, at 12:39 p.m. RN-F at investigation training when with in the last couple months. andy that began on 10/22/15, 18/15, when the facility owing interventions to falls for R61. However, ained at the lower scope and solated, scope and severity diactual harm that is not for R61. Hove the LI, which were ervation, interview and as follows: all risk assessment was for a Basic Metabolic Profile is were completed, alone in his room during thin more activities and 1:1 ace in the wheelchair and in the ere changed and signed by adated, and treatment administration as ordered.	F F	23		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLAA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		246227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	BCTR		16	REET ADDRESS, CITY, STATE, ZIP CODE 301 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAQ	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 323	with high risk resident weekly IDT meeting. On 11/13/15 at 2:01 pundated Root Cause prevention policy. The the daily standup meeting on safety, fadevices, care plan adgroup sheets that direcare." The facility policand Chair" reviewed not substitute for properties of the same reviewed and compared to the side R42's quarterly MDS R42 was cognitively in assistance with bed multiple diagnoses in R42's care plan dated used side rails as ord safety while in bed and The care plan directed or entrapment related. On 11/10/15, at 9:28 a.m. R42's right side in checking for the function word freely up and pulling on the side rails.	ents will be done quarterly to being focused on at the own, the DON confirmed the Analysis Authors was the fall expolicy Identified, "During eting falls are discussed if risk, fall management, justments and updates to ect the non-license staff cy entitled, "Alarms for Bed 10/14 Indicated, "Alarms do er care and supervision." as not secured to prevent erail. dated 9/25/15, indicated nobility. The MDS included cluding quadriplegia. if 10/1/15, indicated R42 ered by the physician for ad to assist with bed mobility. It describes the following to the physician for a staff to observe for Injury	F	323	A. All safety interventions for residents have been added to for licensed staff to assess an document that those interventions are in place and working profits. B. Safety care plans have been reviewed along with CNA casheets for appropriate interventions by 12/18/15. C. A new fall assessment was for all current residents. Completed F1/13/15. D. All residents will have a fassessment on admission or readmission, quarterly and following any fall or significate change. This is ongoing. E. the Director of Nursing/designee is notified immediately of any fall. F. Interventions are reviewed revised as necessary. G. IDT meets Monday through Friday assessing any new fall review and recommend interventions as necessary, and will update care plan as need if IDT meets weekly to discursidents considered high rist falls, care plans reviewed, effectiveness discussed and updated as needed.	TAR d to tions perly. en are s done all ant l and gh ls, ad ed. ass all	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLFA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ATEMENT OF DEFICIENCIES		16 D	FREET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	right side rail was too reported it to staff the On 11/17/15, at 7:21 a observed to be tighter a gap. When interviewed on D stated that the side and when R42 reports put in a maintenance NA-D verified that the tightened, but was not when interviewed on director of maintenance rails for R42's were the added, they do located the facility does place to routinely checkide rails. The facility policy Bed directed maintenance	a.m. R42 verified that the loose for him and he had day on 11/11/15. a.m. the right side rail was ned up. There was no longer 11/17/15, at 9:24 a.m. NA-rails become loose at times she did not feel safe, staff ticket to have it tightened. right side rail had been to sure when. 11/17/15, at 3:43 p.m. the ce (DM)-B stated the side ne correct rails for the bed. Seen up with use. DM-B so not have a process in ck the safety and function of	F	323	I. any side rails will be che weekly to determine that are properly attached to by maintenance. II. Nursing staff will be inserviced on fall, and fa prevention DON will review all falls and fall foll up to assure above is completed. 4. DON will report to QAPI monthly determine any trends, patterns or issue with current fall policy. This will be orgoing. 5. The Director of Nursing/designee we responsible. Completion date of 12-31 2015.	they bed II ow to ss n	
			FS	325			
	` '	ty must ensure that a ble parameters of nutritional veight and protein levels, clinical condition			 Resident # 158 was not affected by alleged deficient practice. Resident is currently stable, MD has determined the resident's weight loss is unavoidable not cancer diagnoses All residents have the potential to be affected by the alleged deficient practice. 	iat clated	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ι`'		DNSTRUCTION		SURVEY PLETED
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1601	EET ADDRESS, CITY, STATE, ZIP COOR ST LOUIS AVENUE LUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ED PRÆFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION CATE
F 325	Continued From page (2) Receives a therap nutritional problem.	68 eutic diet when there is a	FS	325			
	by: Based on observation						
	Findings Include:						
	(MDS) dated 9/30/15, diagnoses of cancer a further identified R158 cognitive impairments	and dementla. The MDS 3 had moderate 5, and was independent p assistance, and a 5%					
	75% of food at meals w served. The assessme had vision impairments	had an average intake of vith regular portions being nt elso indicated that R158 and was a low nutritional onal interventions Included					
	dated 9/30/15, indicate due to a poor memory, of daily living without si and weight loss. The gi	Area Assessment (CAA) d R158 was a nutritional risk Inability to perform activities gnificant physical assistance pal listed on the CAA was tive measure and a care ad.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245227	B, WING			11	/18/2015	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CHY, STATE, ZIP CODE			
BAYSHOR	RE RESIDENCE & REHA	B CTR		-	601 ST LOUIS AVENUE PULUTH, MN 66802			
(X4) FD PREFIX T'AG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTION (IFACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(XI) COMPLETION DATE	
	restrictions, weight los Interventions included provide and serve di monitor intake and monitor and an order for a regular dilacked an order for a monitor for for for a monitor for for for for for for for for for f	d 10/9/15, indicated sutrition secondary to fluid as and infection problems. It is as ordered ecord every meal ower day as dated 11/10/15, included ist. The physician orders sutritional supplement. Itals Summary Included (Ibs) -10% weight change weight change weight change weight change would be a supplement of the breakfast meal. Itals was observed to the breakfast meal. Itals a sup of a cup of coffee. During the	F	325				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTÍFICATIÓN NUMBÉR:	1 ' '		E CONSTRUCTION	COMP	SURVEY PLETED
		245227	B, WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			10	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	8 PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REPERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325	throughout the meal and her toast, staff did sugar or raisins on he meal R158 stated "I dencouraged by the state R158 at 75% of hot toast, leaving the crus of coffee, 1/2 of her mR158 stated "I've had On 11/17/15, at 12:23 eating independently lunch meal. R158 wawith whipped topping 8 ounces (oz) of milk ate 100% of the orang and only bites of the toom. R158 drank 100 During the observation with her dining room to pick up her fork and or then put the fork back herself from the dining herself back to her room to the stated R158's intake to every shift for further of how much R158 at When interviewed on registered nurse (RN) determined if a nutrition of her mineral interviewed on registered nurse (RN) determined if a nutrition.	al of 3 cups during being encouraged to eat and was assisted to put jelly not offer to place brown or hot cereal. During the ion't do eggs" when aff member to eat. The staff R158 an alternative food, cereal, bites of eggs and her at. R158 consumed 3 cups hilk and no orange juice. enough." 8 p.m. R158 was observed in the dining room for the asserved a cup of oranges, tace hotdish, Mexican corn, and 8 oz of coffee. R158 ges and whipped topping acc hotdish and Mexican 194 of her milk and coffee. In R158 was busy playing ticket and would frequently not take a bite of food and a down. R158 then pushed groom table and propelled om via her wheelchair. 11/18/15, at 9:12 a.m. 1-L. stated that every meal is computer kiosk. NA-L also is reported to the nurse on documentation regardless e at the meal.	F	325			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CBA IDENT/FICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			16	REET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 325	registered dietician (Research to weights and food intains the dietician. The RD has a decline in weight resident would be reaprevent further weight was a difficult case, a however, the RD state the dying process. Uppersonal spreadsheet stated R158 was not I weight as the RD repostarting weight as 123 RD stated the starting her admission weight The RD stated that she RD stated that she RD stated that she	utritional supplement. 11/18/15, at 9:05 a.m. the (D) stated residents are to at a minimum, and resident's kes are reviewed monthly by further stated if a resident and food intake, the ssessed for interventions to closs. The RD stated R158 as she was on hospice care, and R158 was not actively in non review of the RD's of residents weight the RD tooked at for a decline in orted she entered R158's and food	F	325	 The Registered Dietician will followeight assessment and intervention gaidelines. This will be engoing. Registerian will continue to work with notaff regarding weight frequency and up. This will be engoing. Weights will taken weekly. Registered dictician will review we weekly to determine any significant of and will communicate with the IDT to determine appropriate interventions. Vecontinue to work with Wound and we committee weekly. Registered dietitist report to QAPI monthly on all significating findings. The RD/designee will be responsible oversight from the Administrator. Completion date of 12-31-2015 	gistered ursing follow- I be ights hanges, Will ight an will cant	
	Intervention undated of review the month to follow inditine. Negative trends treatment team wheth significant weight characteristics (2) RESIDE SIGNIFICANT MED ETHE facility must ensurany significant medical	NTS FREE OF RRORS re that residents are free of	F3	333	1. Resident #109 has had no ill effects alleged deficient practice. 2. All residents would be considered a from alleged deficient practice.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION		SURVEY PLETED
		245227	B. WING			11.	18/2015
	RDVIDER DR SUPPLIER RE RESIDENCE & REHA		•	160	REET ADDRESS, CITY, STATE, ZIP CODE IN STILOUIS AVENUE ILUTH, MN 56802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT DE DEFICIÉNCIÉS Y MUST BE PRECEDED BY FULL LSC (DENTIFY)NG INFÓRMÁTIÓN)	IO PREFIX TAG	`	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	facility falled to ensur-was free from a signification of the findings include: R109's Admission Resthat included Alzheim R109 was place on hilling services due to Al. The physician's order morphine sulfate soluby mouth every 1 houbreath pain (2 mg equilibrium). A review of R109's problewing: On 1/1/15, an entry in medication aide (TM/supervisor on day shin narcotics record book 12/28/15, R109 receiliquid morphine. R109 mg was the equival R109 was given 2 mt. ordered. On 11/17/15, at 9:42 (RN)-C was interview working at that time, a medication error. On 11/18/15, at 11:23 (DON) was Interviewed.	and document review, the all of 1 residents (R109) icant medication error. cord identified diagnoses er's disease. On 12/2/14, ospice services for end of zheimer's disease. s on 12/28/14, directed tion, give 2 milligrams (mg) in as needed for shortness of uals 0.1 milliliters [ml]). ogress notes indicated the indicated per the trained (a) and the nursing fit, and after researching the interest dose of (a) was prescribed 2 mg, and ent of 0.1 milliliters (ml). 20 times the amount a.m. registered nurse ed, and stated she was not and was unaware of the call and stated she reviewed the Quality Assurance (QA)	F	33			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION		E SURVEY IPLETED
		245227	B, WNG			11	/18/2015
	(EACH DEFICIENC	B CTR ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	16 D	REET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		0X5} COMPLETION PATE
F 356	the medication error in 11/17/15, at 12:40 p.m. coordinator (AC)-H state the medication error in the facility policy and Consequences and Mindicated a medication preparation or adminitiologicals which is nephysician's orders. The interdisciplinary team medication regimen for potential medication-rongoing basis. 483.30(e) POSTED NINFORMATION The facility must post on a daily basis: o Facility name, on The current date, on The total number are worked by the following and unlicensed number are worked by the following and unlicensed number are vocational numbers (as of the current date). Certified numbers are of Resident census.	ested to provide a copy of investigation form. On in, the admissions alted she was unable to find investigation. procedure on Adverse ledication Errors dated 2/14, in error is defined as the stration of drugs or of in accordance with the repolicy directed the to review the resident's or efficacy and actual or elated problems on an URSE STAFFING the following information ind the actual hours and categories of licensed grategories of licensed grategories of licensed effined under State law), ides. the nurse staffing data ally basis at the beginning of eposted as follows:		333	3 .Licensed staff and TMAs will complete medication administration reeducation 12/18/15. The transcription process is currently being audited for all new admission and readmissions. This is or going. All medication errors will be reviewed by Nurse Managers and DOI corrective reeducation will be done as as review is complete. This is ongoing 4. Medication error trends and or path will be reported to monthly QAPI committee. This will be on going. The transcription process is being reported the monthly QAPI committee, This will obtain process. 5. The Director of Nursing /designee were sponsible. Completion date of 12-31 2015. 1. No residents were affected by the all deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice.	n N, soon i, erns e to ill be will be	

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA A, BUILDING			(XS) DATE SURVEY COMPLETED			
		245227	a. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	BCTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUT H, MN 66802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUEL SCIDENTIFYENG INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFFCIENCY)		(X5) COMPLETON DATE
F 356	make nurse staffing d for review at a cost no standard. The facility must main staffing data for a min required by State law, This REQUIREMENT by: Based on interview a facility failed to ensure included the actual hor This had the potential residing in the facility. Findings include: A review of the direct facility staffing schedul 1/16/15, indicated pastaff on 13 of 15 days postings for each date hours worked during to director of nursing (DC) were not included on the staff posting to the	readlly accessible to n oral or written request, ata available to the public at to exceed the community tain the posted daily nurse imum of 18 months, or as whichever is greater. is not met as evidenced and document review the a the nurse staff posting burs worked for partial shifts, to affect all 159 residents care staff posting and the attention of 11/2/15, through artial shifts were worked by The direct care staff add not specify the actual	F	356	3. The posting of actual nursing hours lowered so as to be at a level height for wheelchair residents. Hours posted imported hours worked, which include pashilts. 4. An audit will be conducted two (2) per week times 12 weeks to monitor the actual hours, including partial shifts a recorded and posted on the nurse staff posting. Audits will be presented to the monthly QAPI committee to assure compliance with posting of actual hours worked. After three months the QAPI committee will make a recommendation to the need to continue to monitor the posting of hours. 5. the Administrator/designee will be responsible. Completion date of 12-31 2015.	or clude artial times nat are clude ars lon as	

FORM CMS-2687(02-99) Previous Versions Obsolete

Fac@iy ID: 00589

	OF DEFICIENCIES CORRECTION	(X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		246227	B. WING		11/18/2015
	ROVIDER OR SUPPLIER	B CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	
(X4) ID PREFIX 1'AG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY PULL USC (DENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFORENCED TO THE APPROPRIA DEFICIENCY)	
F 356	staff posting was 59 in	o.m. the DON verified the nches from the floor to g, and was not at a height or anyone seated in a	F 350	5. The Administrator/designee will be responsible.	
	483.60(c) DRUG REGIRREGULAR, ACT OF The drug regimen of a reviewed at least once pharmacist. The pharmacist must the attending physicial nursing, and these reputations. This REQUIREMENT by: Based on interview at facility failed to ensure	is not met as evidenced is not met as evidenced is not met as evidenced is consultant pharmacist is promptly addressed for R109) reviewed for	F 428	1. Resident #38 has had no advill effects due to the alleged deficient practice. Resident / less anxious and has minima attempts at trying to remove ostomy bag with current medications. Appetite is impand she is participating in ac Resident # 109 has had no ac of ill effects due to the allege deficient practice. Resident i demonstrating less grimacing moaning, less arching and le grinding of teeth, which has improved his quality of life. 2. All residents have the pot to be affected by the deficient practice.	t38 is I her roved tivties, Iverse ed s g, Icss ss
	that included colostom with mixed anxiety and dementia, delusional of psychotic disorder, R3	8's quarterly Minimum 9/11/15, indicated she e impairment, and			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MURT A, BUJLON	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245227	B. WING_			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		•	STREET ADDRESS, CKTY, STATE, ZIP 1601 ST LOUIS AVENUE DULUTH, MN 55802	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEND	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN DE (EACH CORRECTIVE AC' CROSS-REPERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(XE) COMPLETION CATE	
F 42 8	R38's order summary indicated R38 receive antidepressant medic by mouth in the more obsessive compulsive adjust disorder with rimood; the start date report also indicated furnarate (an antipsystwice a day for parandisorder with a start of R38's order summary antianxiety medication needed for anxiety reand 0.25 mg by moute and 0.25 mg by moute and one of the received rec	r report, dated 11/18/15, ed sertraline HCl (Zoloft) (an eation), 200 milligrams (mg) ing for anxiety with e disorder (OCD) related to nixed anxiety and depressed was 8/15/14. The order R38 received quetiapine choic medication), 50 mg oia retated to delusional date of 8/16/13. In addition, r indicated lorazepam (an en) 0.5 mg by mouth as elated to delusional disorder the two times a day for anxiety a disorder with mixed anxiety.	F	428			
	problem related to lor multiple times a day, type behaviors. The had a mood problem dementia, delusions, The care plan directe observe/record/repore pisodes or feelings and interest in activiti interactions with residuhen she is receiving A 6/19/15, Consultan Review form indicate R38's sertraline (Zoldirregularity comment benefit analysis/docupsychotrople medicar	and cognitive impairment. If d staff to It to the physician any acute of sadness, loss of pleasure ies, and to have positive dent at times other than If medical care. If Pharmacist's Medication If an irregularity regarding					

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION		TE SURVEY MPLETED	
		245227	B. WING			1 4	1/18/2015	
NAME OF PI	ROVIDER OR SUPPLIER	ZASELI		STRE	ET ADDRESS, CHTY, STATE, ZIP CODE		17 10/2010	
BAYSHOE	RE RESIDENCE & REHA	S CTR		1601	ST LOUIS AVENUE			
DRIGHT	TE REGIDENCE & REIF			DULUTH, MN 66802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÉMÉNT ÓF DEFÍCIENCIES Y MUST 82 PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 428	her ostomy bag. Since that has improved, the is recommended at the analysis/documentation suggested course of a versus benefit statem continuation of the Zo	past history of focusing on the starting this medication, erefore, no further reduction his fime-still risk vs. benefit on is required by CMS. The faction was to provide a risk ent and clinical rationale for bloth as ordered. A hand	F.	128				
	psychiatrist. The sign The 10/20/15, consult comment requested a statement for the sert clinical rationale for or guidelines. Under the section "rejected" is of written note indicated this time. Benefits our signature is not legible on 11/17/15, at 2:07 p	tant pharmacist irregularity irisk versus benefit rallne medication, including continuation, per CMS collow-up or action taken ircled and a 10/29/15, hand reduction not indicated at rrently outweigh risks. The collow-up, in an interview						
	R38 was observed an 3:20 p.m., sitting calm R38 made eye contact interacted appropriate R38 was observed on again at 8:10 a.m., ca floor dining room with On 11/12/15, at 8:53 adoorway of her room v On 11/12/15, at 12:24 R38 was observed in 11/15/15, at 8:00 a.m.	d interviewed on 11/9/15, at lay on the edge of her bed. It, answered questions and lay throughout the interview. 11/12/15, at 6:55 a.m. and lamly sitting in the second a beverage in front of her. It is a.m. R38 was in the with a smile on her face. and again at 12:45 p.m.						

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1		CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
		245227	B. WING _			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		160	REET ADDRESS, CITY, STATE. ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFECIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH GORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 428	In an interview on 11/2 stated she doesn't kn brother is her respons doesn't feel like she had brother is her respons doesn't feel like she had be assistent (NA)-J stated gowns, towels and ot colostomy bag off. NA set-up and stand-by a but is independent wi stated they have not anything else. In an interview on 11/2 registered nurse (RN) June 2015, medication practitioner's who rout in an interview on 11/2 stated R38 just started psychiatrist in Octobe 2015, response refer psychiatrist, who did RN-G stated the hand was from the consulta practitioner. RN-G stated the nup a formal risk versurequested from a phy they don't review it with the state of the state of the state of the nup a formal risk versurequested from a phy they don't review it with the state of the state of the state of the nup a formal risk versurequested from a phy they don't review it with the state of the st	two others at the dining rages, waiting for breakfast. 117/15, at 8:44 a.m. R38 ow her medication, but her sible party. R38 stated she has any side effects from her is that they help her. 117/15, at 8:56 a.m. nursing at R38 does hoard sugar, her items; R38 also pulls her ray stated R38 required has assist with personal hygiene, the other cares. NA-J also been told to watch for 117/15, at 2:00 p.m. 117/15, at 2:00 p.m. 117/15, at 2:07 p.m. RN-G divisits with the consultant has at the facility. 117/15, at 2:07 p.m. RN-G divisits with the consultant has see R38 until October. It will be a consultant had see R38 until October and psychiatrist's nurse atted they (the consultant hurse practitioner) don't type has benefit when it's sician. RN-G also stated the residents.	F 42	28	3. The following systems will implemely 12-31-2015 Pharmacist makes recommendations and emails ADON along with DON ADON prints off recommendations, signs, and distributes to appropriate nurmanagers Nurse Managers fax appropriate places in rounding book for Eldercare and Dr. Gish reside Nurse Managers follow throut mursing recommendations from pharmacist As recommendations are addressed by provider and managers are addressed by provider and managers in resident chart and copy is good back to ADON. Original is point resident chart and copy state with ADON ADON uses the "nursing drup report" emailed by consultant pharmacist to check off recommendations that have to back from the nurse manager cusures that the provider responsing appropriate.	se iate rs or ents,	

	OF DEFICIENCIES COMRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	_	(XS) DATE COME	SURVEY PLETED
		245227	B, WING _			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	ID.	STREET ADDRESS, CITY 1601 ST LOUIS AVENU DULUTH, MN 55802	IE		OVE.
PREFIX TAG	(EACH DEFICIENC)	Y MUST 85 PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORI	RESTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	In an Interview on 11/consultant pharmacist for the lapse of time be when no action was to pharmacist stated that versus benefit on the adequate risk versus lapsychiatrist often puts in his notes, which wo the medical record. Note that medical recommen pharmacist, and the fact R109 had recommen pharmacist, and the fact R109's Admission Received from the facilist R109's Admission Received from the facilist included Alzhelmedisorder, depression, arthritis. The quarterly dated 9/14/15, indicate cognitive impairment, total assistance of state transfers, dressing, early lene, bathing and if R109's physician's ord Ativan (an antianxiety (mg) twice a day. Risperdal (an antidepressibedtime. On 8/25/15, the consultation of the Intivan, Risperdal, and medications improve times.	18/15, at 10:23 a.m., the istated he cannot account etween June and October aken. The consultant is in his opinion the brief risk October form was an benefit and that the a more detailed description uld not yet be available in additional information was lity. dations from the consultant acifity did not act upon them. Cord identified diagnoses er's disease, anxiety hypertension, gout and Minimum Data Set (MDS) and R109 had severe and required extensive to ff with bed mobility, sting, mobility, personal colleting. Lers indicated the following: medication) 1 milligram shotic medication) 25 mg at litant pharmacist gave the ant medication 25 mg at litant pharmacist gave the covest effective dose for the Zoloft as well as how these he residents quality of life. Aysician responded with the	F 4:	ADON will re and de is need review by rev recomm ADON that fir provid 4. Any negative to the consultin Any issues with will be discusse committee. Any MD responses t Medical Directo attending physic timely. System 5. The Director responsible with	N and consultant pharmoview questionable respected if further clarificated. Pharmacist will also past due recommendation report with N. Decision will be made as to readdress with ler or Medical Director coccurrence will be reported at the monthly QAPI you going issues with the Facility will contact or to facilitate having the cian respond back more will be on going. Tof Nursing/designee with oversight from the Completion date of 12-	tionses tion so tions the de at corted tely. the the the	

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245227 B. WING		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	11/18/2015	
BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802		
PREFIX (EACH DEFICIENCY XUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X6) COMPLETION DATE	
F 428 Continued From page 80 Risperdal, Question effectiveness, question if experiencing symptoms. The physician's response lacked documentation of how these medications improved R109's quality of life. On 11/17/15, at 8:03 a.m. registered nurse (RN)-G was interviewed, and stated the consultant pharmacist comes to the facility monthly, and she reviews the recommendations with him. On 11/18/15, at 11:59 a.m. the director of nursing (DON) was interviewed, and stated the assistant director of nursing reviews the consultant pharmacist recommendations with him, and the DON was told there was not a problem with them. The facility was unable to provide a policy and procedure on consultant pharmacists recommendations. F 431 483.80(b), (d), (e) DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation: and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.		

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	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPCIER/CLIA IDENTIFICATION NUMBER:	1	FG	(X3	O DATE SURVEY COMPLETED
		245227	B. WING_			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 66802	<u></u>	11110000
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD SIG	(X5) COMPLETION DATE
F 431	Continued From pag	e 81	F 4:	31		
	facility must store all locked compartments controls, and permit a have access to the kill. The facility must provipermanently affixed a controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when package drug distributed.	tate and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to eys. And the separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and and other drugs subject to the facility uses single unit ation systems in which the timal and a missing dose can				
	by: Based on observation review the facility fails stored at the required medication refrigerate failed to provide secular the first floor nurse. Findings include: On 11/13/15, at 9:25 medication refrigerate observed to be 32 dethermometer and 29 of thermometer. The but	a.m. the Morning Light West or temperature was grees Fahrenheit (F) on one				
	into the refrigerator. A log Indicated the acce	A review of the temperature eptable range was 36-46 emperature had been within				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		SURVEY PLETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	в стя		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE IJLIJTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUEL LSC IDENTIFYING INFORMATION)	(D PRSF3) TAO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X6) COMPLETION DATE
F 431	indicated the facility of refrigerator temperature in the temperature in the momentum and 29 of the manufacturer's prinsulin stored in the directed the following. Unopened Novolog size frigerator between 3 degrees Figerator at 36 degrees Figerator and should been frozen. Unopened Humulin Nize frigerator at 36 degree frigerator at 36 degrees frozen. Unopened Humalog ship frefrigerator at 36 degrees frozen. Unopened Humalog ship frefrigerator at 36 degrees. The refrigerator contain opened resident intition diabetes) pens: R1 7 Lantus pens. R1 7 Lantus pens. R1 8 Jantus pens. R1 9 Lantus pens. R1 9 Lantus pens. R1 1 Humulin Niper. R1's signed physician included a diagnosis with diabetic peripher.	days. The temperature log thecked the medication ares once daily. Licensed -C verified the frost build up was 32 degrees F on one degrees F on the other. ackage Inserts for the medication refrigerator: thould be stored in a 36 degrees F and 46 degrees F and 4	F	431			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENEIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COME	SURVEY PLETEID
		246227	B, WING			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			1	TREET ADDRESS, CITY, STATE, ZIP COUE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX 1AG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 431	included a diagnosis of complications. The phroper inject subcutaneous solution two times dail R87's signed physicial included a diagnosis of complications. The phroper inject subcutaneous solution in the morning scale dose up to 8 uniorders also directed s 10 units of Lantus solution in the morning included a diagnosis of with diabetic meuropaid directed staff to inject Novolog solution ever inject 17 units two time orders also directed s 10 units of Lantus solution diabetic neuropaid included a diagnosis of the complications of the complications of the complications directed staff to inject Humulin solution daily units subcutaneously. When interviewed on registered nurse (RN) insulin from the medic contact the pharmacy	an orders dated 11/10/15, of type 2 diabetes without hysician orders directed staff sly 10 units of Lantus ly. In orders dated 10/8/15, of type 2 diabetes without hysician orders directed staff sly 4 units of Humalog g in addition to a sliding lits daily. The physician taff to Inject subcutaneously ution at bedtime. Orders dated 11/5/15, of type 2 diabetes mellitus thy. The physician orders subcutaneously 10 units of y evening with supper and less daily. The physician taff to inject subcutaneously ution every 12 hours. Orders dated 11/10/15, of type 2 diabetes mellitus. The physician orders subcutaneously ution every 12 hours. Orders dated 11/10/15, of type 2 diabetes mellitus. The physician orders subcutaneously 20 units of at bedfime and to inject 25 one time daily. 11/13/15, at 9:47 a.m. B stated she will pull the lation refrigerator and consultant for instructions.	F	131			
	verified the insulin per	11/18/15, at 9:50 a.m. RN-B ns were destroyed and had I stated that a maintenance					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA #DENTIFICATION NUMBER	1, ,		CONSTRUCTION	(XS) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015
BAYSHOF (X4) ID		B CTR ATEMENT OF DEFICIENCIES	ID PREFI)	16 D	TREET ADDRESS, CITY, STATE, ZIP CODS 391 ST LOUIS AVENUE ULUTH, MN 66802 PROVIDER'S PLAN OF CORRECTION		(X5)
라유EFIX TAG		CHIDERCIENCY MUST BE PRECEDED BY FULL BULATORY OR LSC IDENTIFYING INFORMATION)		Κ	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		GOMPISTION BATE
F 44 1	director of nursing (Dr pens were reordered refrigerator was on or the medication refrige getting old. The facility policy Sto 4/14, directed medical or temperatures betw degrees F are kept in thermometer to allow On 11/12/15, at 8:15, insulin pens were obsinurse's station, near trinsulin pen had approin it, and the Lantus in approximately 130 uncontinuous observations: 45 a.m. the insulin pand staff and resident door. At 8:45 a.m. regpicked up both insulin them on the desk bed administer it after bream to normal practice to unsecured. On 11/18/15, at 12:09	11/18/15, at 10:20 a.m. the ON) stated that the Insulin and a new medication der. The DON further stated trators in the facility are rage of Medications dated tions requiring refrigeration een 36 degrees F and 46 a refrigerator with a temperature monitoring. a.m. Novolog and Lantus terved at the first floor he open door. The Novolog ximately 70 units of insulin asulin pen had lits of insulin finit. During on from 8:15 a.m. through pens remained on the desk, is were passing by the open pistered nurse (RN)-D a pens, and stated she left ause she was going to akfast. RN-D stated it was leave insulin pens		441	3. The medication refrigerators were rewith new refrigerators. The License statemps on a daily basis; the License statemps on a daily basis; the License statemps of medications which includes insulin pens. Completed 12-18-2015. 4. An audit will be conducted one (1) per week times 12 weeks to monitor it refrigerator temperatures for the properstorage of medications in the refrigeration rounds will be conducted (1) times per week times 12 weeks to monitor proper storage of medications including insulin pens by nurse manage Any negative occurrence will be address including insulin pens by nurse manage Any negative occurrence will be address including the monthly QAP1 commute monitor the proper storage of medications. After three months the Quentities will make a recommendative the need monitor that the temperature logs are being documented daily. Refrigerator temperature logs will be collected weekly and placed in a three binder. Logs will be kept for one year 5. The Director of Nursing/ designed weekponsible with oversight by the Administrator. Completion date of 12-31-2015	aff and frand frand frand frand frand frand frand frand france fr	
			1		†		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE IULUTH, MN 65802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ESC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EAGH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		Æ	(XA) COMPRETION DATE	
F 441	safe, sanitary and conto help prevent the de of disease and infection. (a) Infection Control P. The facility must estat Control Program under (1) Investigates, control in the facility; (2) Decides what proceshould be applied to an (3) Maintains a record actions related to infection determines that a resignificant the spread of must isolate the reside (2) The facility must procommunicable disease from direct contact with if direct contact will train (3) The facility must rehands after each direct which hand washing is professional practice. (c) Linens Personnel must handle transport linens so as of infection.	ram designed to provide a infortable environment and velopment and transmission on. Program collish an infection er which it - cols, and prevents infections edures, such as isolation, individual resident; and a corrective ctions. If of incidents and corrective ctions. If of infection is control Program dent needs isolation to infection, the facility ent. The infected skin lesions in residents or their food, ansmit the disease, equire staff to wash their est resident contact for indicated by accepted. If of incidents and corrective ctions is indicated by accepted.	F	141			
	by:	is not met as evidenced ı, interview, and document					

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				(X3) DATE SURVEY COMPLETED	
	245227	B. WING	p <u> </u>	11/18/2015	<u> </u>
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID SUMMARY STATEMENT I PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR USC IDENTI	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLE DATS	тіон і
F 441 Continued From page 86 review, the facility failed to imponitor resident Infection facility falled to ensure appropand gloving practices were prefer 1 of 1 residents (R49) obsilin addition, the facility failed to precautions for 1 of 1 resident with methicillin resistant staph (MRSA) infection. The facility implement contact precaution residents (R88) diagnosed wire clostridium-difficite (G-Diff) Inferentices had the potential to residents in the facility. Findings include: In an interview on 11/17/15, a stated three residents current isolation precautions. RN-B stated three residents. RN-B stated three residents. RN-B stated the door sign (directed with the nurse before enurse what precautions they rentering a room. In the interview on 11/17/15, a stated each nursing station reresidents had infectious symptemperatures, coughing. RN-I residentprogress notes daily a morning report in order to gat related to potential infections. RN-B stated she educated stafoam out" of rooms. If a residentey are to wash their hands of the page 1/2 residented to potential infections.	entify, document s. In addition, the briate hand washing bovided during cares betwed during cares. between the contact is (R111) diagnosed bylococcus aureus between alied to s for 1 of 1 th ection. These affect all 159 It 2:47 p.m., RN-B by were currently on tated she hasn't con of precautions between all people to intering) and ask the meed to take before at 2:47 p.m., RN-B boorded what between the contact of the contact of the contact of the between the contact of the contact of the contact of the boorded what between the contact of the contact of the contact of the boorded what between the contact of the contact of the contact of the boorded what between the contact of the contact of the boorded what between the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the	F 44			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24 5 227	B. WING	.	<u></u> _	11	/18/2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFU TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	would talk to individual manager know. RN-B stated she had prevention and control September, teaching person could not atterpacket of the presents not reviewed to determine the received this education. In an interview on 11/ Occupational Therapist we evaluating therapist we evaluating therapist we evaluation meeting with was on precautions. Offer the facility, nursing way and she would interest and she would interest on a one-OT-D stated there we new to the facility and was a fot of uncertaint infection precautions, re-educated her staff I and glove prior to work in their room. OT-D is sani-wipes (a disinfect therapy equipment an an infectedresident is session.	s. If she saw a concern she all staff and then let their done a full infection of the class at the end of 5 or 6 classes. If a staff and, they were to review a ation and sign off. RN-B has mine if all staff have in. 17/15, at 3:38 p.m., the st (OT)-D stated the ould find out during an initial this a resident if that resident DT-D stated that the down" to other therapists, and became infectious while would inform her in some form her staff the best she by-one basis. The a lot of new therapy staff; to the profession, and there y around implementation of OT-D stated she had to wash hands, and gown king with infected residents tated therapists use ant) to wipe down all discovered when done with their therapy	i	441			
]	the room, they should	e just going in and out of put on gloves; if they are any surface in the room,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		'	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFX YAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DESIGIENCY)		(X5) COMPLETION DATE
F 441	train housekeeping at stated that putting a r housekeeping cart to not be done. RN-B st resident or infection-s departments. In an interview on 11/Maintenance (M)-A st to remove a soiled duafter using it in a roor stated staff are not to additional rooms. In an interview on 11/stated she reviewed adily upon her arrival there were any infection antibiotic therapy, information on reside reading a dally log which specific information, a her or she would read R49 did not receive a during daily cares. R49 's admission redincluded failure to thricestlessness and agit annual Minimum Data indicated R49 had se required extensive as transfers, dressing, e	gloves, RN-B stated her area, so she doesn't aff on infection control. She hop back on the use in another room should ated she has not done any pecific training across other. 18/15, at 7:42 a.m., tated housekeeping staff are st mop and get it laundered in with precautions. M-A use the dust mop in. 18/15, at 8:42 a.m., RN-B all resident progress notes in the facility to determine if on control related issues, e to inform her if anyone is RN-B stated she gathered int's with infections by here nurses record resident in nurse manager would teil it in the progress notes. In the facility to determine if on control related issues, e to inform her if anyone is RN-B stated she gathered int's with infections by here nurses record resident in nurse manager would teil it in the progress notes.		441			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	ľ	(X3) BATE SURVEY COMPLETED		
		245227	B. WING_			11/18/2015		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1801 ST LOUIS AVENUE DULUTH, MN 55802	IE.	111012010		
(X4) ID PREFIX TAG -	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION GROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD ВЕ	(XS) COMPLETION : DATE		
	and NA-G were obserwithout using hand sabetween glove change According to NA-G, Rewas saturated with uribowel movement. NA cleaning BM off of R49 wipes. After cleaning and NA-F took off their handwashing or hand gloves. NA-F then too washed under R49's b NA-G tied up the garbincontinent product an on the floor.NA-G their room, removed her gich hand-sanitizer. In an interview on 11/1 registered nurse (RN)-monitored hand washing the audits in July of 20 hand-washing formally. The facility's undated if Control Program sections.	of R49's cares on a nursing assistants (NA)-F wed to change gloves nitizer or handwashing in es. 49's incontinent product the and R49 had also had a serial NA-G took turns es with disposable wet R49's perineal area, NA-G regloves and without sanitizer, donned new ok a well washofoth and reasts and her armpits, age with the soiled did wet wipes and placed it in brought a stand lift into the oves and used 17/15, at 2:47 p.m., B stated that she hasn't are formally. She did do a possible to be completed by giene to be completed	F4	441				
ĺ		resistant staphylococcus on and the facility did not infection control						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245227	B. WING			11/	18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 65802				
(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 B GROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 441	included methicillin reaureus infection, peri aneurysm of artery of admission minimum of 8/31/15, indicated he had surgical wounds. An 11/15/15 progress R111's left heel. The bilister had popped withe area was cleane applied a non-stick prophysician orders for y clean the wound, applied a hon-stick prophysician orders for y clean the wound, applied a hon-stick prophysician orders for y clean the wound, applied a hon-stick prophysician orders for y clean the wound, applied a hon-stick prophysician orders for y clean the wound, applied and head and an addition the IAR in medication sulfameth antibiotic) for 14 days. In an observation on R111's room had an outside the room, but directing staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering and the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering and the prophysical staff or visite before e	ord identified diagnoses that esistant staphylococcus pheral vascular disease, and a lower extremity. R111's data set (MDS), dated was cognitively intact and anote indicated a blister to note continued that the thyellowlsh/red drainage, dwith wound cleaner and ad and wrapped. 11/16/15 wound care directed staff to oly telfa and tegaderm eragency Referral Form identified MRSA as a high on the first page of the form. dicated R11 was on a new exazole-trimethoprim (and after discharge. 11/15/15, at 7:04 a.m., infection control station in sign on the door ors to check with the nurse observation on 11/17/15, at nere was still no sign on lad a sign put on R11's door	F	441				

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11.	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245227	B, WING			11/18/2015		
NAME OF P	ROVEDER OR SUPPLIER	242221		STREET ADDRESS, CITY, STATE,	L ZIP CODE	11/10/2010		
BAYSHO	RE RESIDENCE & REHA	B CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG				(EACH CORRECTIVE GROSS-REFERENCED		(X5) COMPLETION DATE		
F 441	41 Continued From page 91		F	441				
	stated CDC guideline which isolation precaudid not know if all thresheen cultured and if no why they weren't. RN check." No further clark-B also stated any precautions, they don In an interview on 11/stated R111 had return 8/25/15. RN-B stated R111's leg wound had resident on contact pr R111 was not on contact precautions only durin R88 had a Clostridium infection, and the facili appropriate infection of Findings include: The Center for Diseas for health care facilities when caring for reside infection: Isolate patie immediately. Wear glot treating patients with 6 visits. Hand sanitizer of although hand washin not be sufficient alone gloves. Clean room sudaily basis while treating and upon patient discissupplement cleaning of Supplement cleaning supplement	arification was provided. Inurse can implement It have to wait for orders 18/15, at 8:42 a.m., RN-B med from the hospital on as soon as she found out If infection she placed the recautions. RN-B confirmed recautions from In the hospital, until RN-B rons on 9/1/15. RN-B stated entation was for staff to use reg wound cares. In difficile (C. difficile) rity did not implement control precautions. If Control (CDC) guidelines as directed the following rents with a C. Difficile rows and gowns when C. difficile, even during short does not kill C. difficile, and g works better, it still may thus the importance of refaces thoroughly on a ring a patient with C. difficile rearge or transfer.						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1.	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015
•	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1601 ST LOUIS AVENUE DULUTH, MN 55802	Œ		
(X4) ID PREF;X TAG	SUMMARY 87A1 EMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FURE REGULATORY OR LIST IDENTIFYING INFORMATION)		IC PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD)			(X5) COMPLETION DAT≌
F 441	Included enterocolitis (a spore-forming bact and irritation of the lar inflammation, known diarrhea, fever, and a R88's admission Mini indicated R88 was co extensive assistance was frequently incont results on 9/24/15, ar the presence of C. dif On 11/8/15, at 3:42 p was interviewed, and precautions due to a stated staff were not i prior to entering R88's coming into direct cor verified R88 had toos On 11/10/15, at 7:34 (NA)-L was observed was a yellow sign on contact precautions, v Visitors see nurse be door was an isolation masks and sanitizing coffeepot in her hand entered R88's room. I hands, or put on a go coffeepot on a bedsic Housekeeper (H)-A ti did not wash her hand had a dry mop, and p floor. NA-L proceeded left the room without i placed the dry mop o NA-L teft the room wit	ord identified diagnoses that due to Clostridium difficile eria that can cause swelling rge intestine, or colon. This as colitis, can cause bdominal cramps). mum Data Set (MDS) gnitively intact, required of two staff for toileting, and inent of bowel. Laboratory id 10/13/15, both identified ficile in R88's stool. m. registered nurse (RN)-C stated R22 was on isolation C. difficile infection. RN-C required to gown and gloves room, unless they were stact with R88's stool. RN-C estools that day. a.m. nursing assistant entering R88's room. There R88's door; it directed "stop wash hands, gown, glove, fore entering". Outside the cart with gowns, gloves, wipes. NA-L had a s, knocked on the door and NA-L did not wash her wn or gloves. NA-L put the	F	141			

Facility IC; 00588

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CEMA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING		- Hanned	11	/18/2015
NAME OF PROVIDER OR BAYSHORE RESIDE		B CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
'	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (FACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
the room, did not go room, becand made washed? was on hinterviewed when going alcohol by 7:57 a.m., on her ho supposed cart, and not done On 11/10 alde (TM/did not has thermome stated if the clean there is supposed to wash the clean there is supposed cart, and not done On 11/10 alde (TM/did not has thermome stated if the clean there is supposed in the clean the clean there is supposed in the clean the clean there is supposed in th	own or glove cause she jue his bed. N/her hands wher hands wher way to do ed and stateing into R88's ased sanitized. H-A was obsusekeeping if to take the replace it will this yet. (15, at 10:05 A)-E was into a dedicate or blood hese were used of R88's door, helr hands welcohol base and leaving the pect nursing the pect nursing the pect nursing the pect nursing the whether or digloves, or then entering facility did not retering fac	nterviewed and stated she when she went Into R88's st brought him fresh coffee, A-L stated she had not be leaving the room, she that now. H-A was dishe did not gown or glove is room, but she did use an er when she left the room. At served with the dry mop still cart. H-A stated she was soiled dry mop off her her that a clean one, but she had a.m. trained medication prviowed, and stated R88 ted stethoscope, pressure cuff. TMA-A sed on R88, staff should	F	441			

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STATEMENT OF DEFICIENCES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING			COMPLETED				
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	AB CTR		1601 ST	ADDRESS, CRY, STATE, ZIP CODE LOUIS AVENUE H, MN 55802		
(X4) ID 유REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC'I'ON (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERINGED TO THE APPROPRI DEFICIENCY)	}E	(K5) COMPLETION DATE
F 441	do it soon. RN-B statt blood pressure cuff, sthermometer on R88, equipment with a san educated them on it y. In an observation on certifled occupational was observed enterinclipboard. The COT/Froom entry, but did a COTA did not touch a handle to close the did not wash or sanitithe room. The COT/Fithe clipboards to use On 11/12/15, at 7:14 and stated the sanitizer cart outside of R88's. The facility policy and Difficite undated, directive in remove When possible, non-should be declicated. Based on interview a facility failed to ensure screening, including a test (TST) (a skin test individual had been einfected with TB), and screening was complipator to providing care	and the facility will start to ed if staff were using the stethoscope and they should be cleaning the sitizing wipe, but she hasn't yet. 11/10/15, at 10:29 a.m., I therapist assistant (COTA) ag R88's room with a A did not gown or glove upon pply hand sanitizer. The anything, but did use the door oor upon exit. The COTA ize her hands after exiting a stated that she would take in other rooms. a.m. RN-B was interviewed, ting wipes on the isolation room did not kill spores. I procedure on Clostridium rected staff to wash hands alcohol gels or handrubs are ving or killing the spores a critical care equipment to the patient with C. difficile, and document review, the re Tuberculosis (TB) a two-step tuberculin skin t to assist in identifying if an exposed to TB or was d a TB baseline symptom leted upon employment and leted upon employment and letes for 9 of 10 direct care litential to affect all 159	F	41			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	NG	(X3) DATE SURV COMPLETE		
		245227	B. WING_		11/18/2	015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CRY, STATE, ZIP CO 1801 ST LOUIS AVENUE DULUTH, MN 55802		
(X€) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BS co.	(X6) MPLCTION DATE
F 441	Continued From page	96	F4	141		
	Health-Care Setting, health care workers in screening upon hire. an assessment of the TB, and any current TST (tuberculin skin togamma release asset)	for Preventing the obacterium Tuberculosis in 2005 (MMWR) directed all nust receive a baseline TB. The screening must include employees risk factors for TB symptoms. A two-step est) or a single interferon (IGRA), or a chest x-ray ained in the employee.				
	and employee list ind * NA-N was hired 3/1 tuberculin skin test TS	Ž.				
	5/30/13. The second- administered late. NA-O was hired 10, was administered on was administered 6/1	step TST was /27/14. The first-step TST 6/3/15 and the second TST 0/15. The baseline				
	The screening was not NA-G was hired 10/1 was administered on 10 receive a second-step screening was complet * NA-M was hired on TST was administered step TST had not bee baseline symptom scr 10/26/15. * NA-P was hired on	TST. The baseline symptom ed on 10/15/15. 10/26/15. The first-step d on 10/26/15. The second-				
	had not been administe	•				ĺ

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		ATE SORVEY OMPLETED
		245227	B. WING_			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REH/	***************************************		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	:	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMONT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(AX) COMPLETION BATE
F 441	completed on 5/17/1 * NA-Q was hired or TST was administered second-step was adrifted by the TB screening was time of hire. * NA-R was hired or TST was administered another one second-step TST was administration, the Tafter administration, screening was completed a TST on 9/4 at facility. The first-st on 10/26/15. The base was completed on 10 and the total term of this date. The term of the dated 12/2/14, screening was completed on 10 and the term of the dated 12/2/14, screening was completed on 10 and the term of the dated 10/24/14 was administered 10/24/14 registered nurse (RN) have a negative TST is residents, and the second the term of the	e symptom screening was 1. 1 12/26/12. The first-step ed on 10/24/14. The ministered on 12/17/14. In screening was undated. In screening was administered with each many screening was administered. In screening was undated with each many screening was screening was screening was screening was undated. In screening was undated.	F4	1. No residents were affalleged deficient practice. 2. All residents have the be affected by the all practice. 3. Staff will be in-serviced on Infection control Policies and which includes the implement isolation precautions and ensuband washing. The Staff Deve Anfection Control Coordinator implement infection control proceedings in a timely mapon admission or readmission current resident if precautions 4. Observation rounds will be (2) times per week times 12 with monitor the facility's infectior include isolation precautions a hand washing. Any negative of be addressed immediately.	e potential to eged deficient the Facility's Procedures, ation of bring complete clopment r will recautions per anner. And n. or with any are warranted conducted two reeks to n program to and complete	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		SURVEY
		245227	8 WING			11	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	TREET ADDRESS, CRTY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMIENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION INATE
	TSTs repeated becau their second-step TST stated the employee is them when they need have the first-step TST second-step TST adm followed up with huma. The undated facility per Tuberculosis Control fapplicants for employing a two-step TST tuberculosis, 483.70(h)	se they were late having "administered. RN-B s given a form that directs to come back either to F read, or have the ninistered. RN-B stated she an resources. clicy and procedure for Plan directed all qualified ment would be screened or a blood test for	F4	165	The results of the observation rounds be presented to the monthly QAP1 committee to review and make recommendations. After three months QAPI committee will make a recommendation as to the need to conto monitor the facility wide infection control program. 5. The Director of Nursing/designee with esponsible with oversight by the Administrator. Completion date of 12-31-2015	the tinuc	
	sanitary, and comfortaresidents, staff and the This REQUIREMENT by: Based on observation review, the facility fails were well maintained if (rooms 121, 143, 151, addition, the facility fails was properly maintain (R129) reviewed for elforthings include: On 11/17/15, at 2:59 prompleted with the dim (DM)-B and the enviro	able environment for a public. Is not met as evidenced In, interview and document and to ensure resident rooms for 8 of 15 resident rooms 159, 160, 210, 212, 267) In alled to ensure a wheelchair and for 1 of 1 residents evironmental concerns.			 Resident room's il 121,143,151,159,160,210,212,257 and wheelchair in room 129 were repaired, painted and or fixed to reflect a more homelike environment. All resident rooms have the potential not having a homelike environment. 		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LE CONSTRUCTION	(X3) DATE COMP	\$URVEY PLETED
		245227	B. WING		11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	P CTR		STREET ADDRESS, CSTY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING IMPORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 465	confirmed by both DM Room (RM) 121 had it sharp edges in the vir the main door. RM 143's bathroom h rim of the toilet. The o tollet was cracked, pe four dime sized chips bathroom. The built in exposing the particlet corner. RM 151's caulking at cracked, peeled and o a strong urine smell. RM 159's caulking at cracked, peeled and o RM 160's bathroom s porcelain. RM 210's bathroom fl around the base of th the corners behind th- There were also dark floor near the toilet. RM 212's private roor RM 257's tiled bathro	erns were identified and II-B and ED-A. II-B and ED-A. III-B and ED-A.	F 46	3. The facility utilizes the Direct Super Tels" system, which allows all departs allow to alert the Maintenance department of resident rooms, resident environment the resident's equipment that need regattention. An audit of ten (10) reside rooms will be conducted each week to assure the rooms are maintareflect a more homelike environment item or items needing repair, painting fixing will be addressed immediately system will be ongoing throughout to The results of the audits will be presente monthly QAPI committed monthly three (3) and quarterly thereafter for a year to assure a system of maintaining resident rooms in a homelike environ	of and or pair or nt ior 12 ined to . Any ; or . This me year, anted to ly for line g the	

NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB OTR CV4) 10 CV4) 10 EGACH DEPLICATIVE VISIT SELEMENT OF PERCICIONGES FOR MANAPY STATEMENT OF PERCICIONGES EGACH DEPLICATIVE VISIT SELEMENT OF PERCICIONGES FOR MANAPY STATEMENT OF PERCICIONGES FOR MANAPY STATEMENT OF PERCICIONGES EGACH DEPLICATIVE VISIT SELEMENT OF PERCICIONGES FOR MANAPY STATEMENT OF PERCICIONGES FROM THOUGH AND SELEMENT VISIT SELEMENT OF PERCICIONGES FROM THE PROPERTY OF THE APPROPRIATE CONSISTENCE TO THE APPROPRIATE CONSISTENCE OF THE APPROPRIATE C		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA FDENTIFICATION NUMBER:	1''		CONSTRUCTION		SURVEY PLETED
BAYSHORE RESIDENCE & REHAB CTR CA910 CA910 PRETRY TAG SUMMARY STATEMENT OF PERCEDENCES (EACH OFFICIENCY MUST be refered by TYLL RESULATORY OR USE DIDNIFFINIS REGIDENCY RESULATORY OR USE DIDNIFFINIS REGIDENCY TAG FACTOR CHECKING AND THE REPORT OR USE DIDNIFFINIS REGIDENCY TAG FACTOR CHECKING AND THE REPORT OF THE APPROPRIATE CONTINUED TO THE ADMINISTRATION OF THE ADMIN			245227	B. WENG			11	/18/2015
FASS FASS Continued From page 99 R129's wheelchair's right-sided arm support was worn through the top layer exposing the cushion. After the four on 11/17/15, at 3:33 p.m. DM-B stated the has not been currently performing routine maintenance rounds in the resident rooms since the ED-A stated working in the facility monthly, however his checklist did not include maintenance specific tasks to lock for and document for follow up. DM-B stated the facility does not have any from maintenance policles aside from housekeeping. The facility policy "Resident Restroom Cleaning" directed housekeepers to sweep, dust and morp the entire floor, moving any items that may be in the bathroom. The facility did not provide a policy on maintainence of resident's comp, resident's equipment F 494 483.75(e)(2)(3) NURSE AIDE WORK > 4 MO - SSSE TRAINING/COMPETENCY A facility must not use any Individual working in the facility as a nurse eide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, approved by the State as meeting the requirements of §\$483.154.63 of this part; or that individual has been deemed or determined competent as provided in §483.150(6) and (6). A facility must not use on a temporary, per diem,			BCTR		16	601 ST LOUIS AVENUE		
R129's wheelchair's right-sided arm support was worn through the top layer exposing the cushion. After the tour on 14/17/15, at 3:33 p.m. DM-B stated he has not been currently performing routine maintenance rounds in the resident proms since the ED-A started working in the facility. ED-A stated that he rounds every room in the facility monthly, however his checklist did not include maintenance specific tasks to look for and document for follow up. DM-B stated the facility does not have any room maintenance policles aside from housekeeping. The facility polloy "Resident Restroom Cleaning" directed housekeepers to sweep, dust and mop the entire floor, moving any items that may be in the bathroom. The facility did not provide a polley on maintainence of resident's rooms, resident's environment or resident's equipment. F 494 483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any Individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §4:483.154 of this part; or that individual has been deemed or determined competency and program approved by	PRÉFIX	(EAGH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
leased, or any basis other than a permanent employee any Individual who does not meet the	F 494 SS=F	R129's wheelchair's ri worn through the top I After the tour on 11/12 stated he has not bee routine maintenance r since the ED-A started ED-A stated that he rotacility monthly, hower include maintenance s document for follow up does not have any rocaside from housekeep. The facility pollcy "Redirected housekeeper the entire floor, moving the bathroom. The facon maintainence of redenvironment or reside 483.75(e)(2)-(3) NURS TRAINING/COMPETE A facility must not use the facility as a nurse amonths, on a full-time is competent to provide related services; and the completed a training a program, or a compete approved by the State requirements of §§483 or that individual has be competent as provided. A facility must not use leased, or any basis of	ght-sided arm support was layer exposing the cushion. 7/15, at 3;33 p.m. DM-B in currently performing ounds in the resident rooms divorking in the facility. Sunds every room in the ver his checklist did not specific tasks to look for and p. DM-B stated the facility or maintenance policles bing. sident Restroom Cleaning stock to sweep, dust and moping any items that may be in sility did not provide a policy sident's rooms, resident's not's equipment. SE AIDE WORK > 4 MO - SNCY any Individual working in aide for more than 4 basis, unless that individual enursing and nursing hat individual has and competency evaluation ency evaluation program as meeting the 3.151-483.154 of this part; seen deemed or determined in §483.150(a) and (b). on a temporary, per diem, ther than a permanent			with oversight by the Administrator w responsible. Completion date of 12-31-2015. 1. No residents were affected by the all deficient practice. 2. All of the nursing assistant evaluation have been completed. Completion date	ill be leged	

	OF DEFICIENCIES CORRECTION	(A1) The first term of the fir		PLETED			
		Z45227	B. WING			11.	/18/2015
NAME OF PE	ROVIDER OR SUPPLIER			รา	REST ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOR	RE RESIDENCE & REHA	B CTR			e1 ST LOUIS AVENUE ULUTH, MIN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(XS) COMPLETION DATE
F 494	this section. Nurse aides do not in furnish services to resassistants as defined This REQUIREMENT by: Based on interview a facility failed to ensur were completed for a past 12 months. This all 159 residents residents residents include: A review of 15 employees performance reviews months: Nursing assi N, NA-Z, NA-R, NA-C During an interview of the human resources NA performance reviews and performance reviews and performance reviews the human resources NA performance reviews the human resources NA performance reviews and performance reviews the human resources NA performance	graphs (e)(2)(i) and (ii) of clude those individuals who sidents only as paid feeding in §488,301 of this chapter. Its not met as evidenced and document review the e performance reviews ill nursing assistants in the had the potential to affect ding in the facility. Its not met as evidenced and document review the experior assistants in the had the potential to affect ding in the facility. It was files Indicated the did not have completed in the past 12 stant (NA)-D, NA-Q, NA-C, NA-V, and NA-W. In 11/18/15, at 9:04 a.m. director (HRD)-I stated no ews were completed in the stated the last reviews yithe previous company. In 11/18/15, at 12:06 p.m. performance reviews were at the evaluation dates found	F	494	3. The Administrator reviewed the ferequirements and the Standards of the of Minnesota with the Director of Nur and the Director of Human Resources regarding the requirement of nursing assistants having an annual evaluation the beginning of each month, IR will out an evaluation form and a list of the CNA anniversary dates for that month will be the expectations that the Unit Managers complete the evaluation by end of that month. 4. An audit will be completed monthly three (3) months, then quarterly for ony year to assure evaluations are completed the State of Minnesota standard. These audits will be presented to the monthly QAPI committee to monitor the system annual evaluations are being complete.	State sing . At send . It the the ed per es y n of	
	in the employee files HRD stated the expe performance reviews						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GUA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
		245227	B. WING			11	/18/2015
NAME OF PI	ROVIDER OR SUPPLIER	atvaar		81	REET AUDRESS, CITY, STATE, ZIP CODE		110,2010
- 4./4/4				16	601 ST LOUIS AVENUE		
BAYSHOR	RE RESIDENCE & REHA	B CTR		D	ULUTH, MN 55802		
(X4) ID		ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(%4)
PREFIX TAO	'	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFID YAG	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION DATE
:					5. The Director of Nursing /designed a	nd	
F 494	Continued From page	101	F-	494	the Director of Human Resources/ desi	ignee	
					will be responsible with oversight by t	ne	
		e for performance reviews			Administrator.		
E //05	was not provided.	AIDE WORK < 4 MO -		40=	Completion date of 12-31-2015,		
	TRAINING/COMPETS		Γ.	495	Completion age of 12-01-2015		
00-1	TOMINATOOOMI ETE	1401	1				
		any individual who has	1				
		onths as a nurse aide in that	1				
	facility unless the indiv employee in a State-a				1. No residents were affected by the all	leged	
	competency evaluatio				deficient practice.		
		ence through satisfactory			2. No residents were affected by the al	leged	i
		e-approved nurse aide			delicient practice.		
		icy evaluation program or					
		n program; or has been d competent as provided in					
	§§483.150(a) and (b),	2 competent as pravided in	İ	Į			
	50 (-),(-),			ĺ			
		is not met as evidenced					
	by: Rased on interview at	nd document review, the					
		new employees receive					
	appropriate orientation						
	providing direct care to	residents. This has the]			
		59 residents residing in the	1			1	İ
	facility.		Ì	Į		Ì	
	Findings include:						
		training Indicated nursing					
		AA, and NA-G had not				ļ	i
	received new employe						
	employee list indicated 10/26/15, and the sche	nA-M was nired on dule indicated she had					
		zares. NA-AA was hired on			-		
		ile Indicated he has been		- 1			
	providing direct cares.						
			1	[

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPE/ER/CLIA 3DENTSFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETIED
		245227	B.WING_		and a first transfer of the second se	11/	18/2015
	ROVIDER DR SUPPLIER RE RESIDENCE & REHA	B CTR		16	REET ADORESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 495	been providing direct 10/26/15, and the sch been providing direct During an interview or registered nurse (RN NA-AA,NA-G, and N/employee orientation attend 12/9/15. RN-B receive some information number of some information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information orientation. A facility policy and policy and policy and interview of the second sure what information.	nedule indicated she had cares. NA-T was hired on hedule indicated he had cares. In 11/18/15, at 8:30 a.m.)-B verified NA-M, A-T had not attended new and were scheduled to stated new employees ation in their packet from R) when they start. RN-B formation they receive from the had not educated the abuse prevention, trights. In 11/18/15, at 12:08 p.m. the stated new employees regarding payroll, job conduct, and resident rights, employment information. The onot receive Information on the receive Information is held. Orientation Training indicated infection prevention and a were to be included in the receivee for new employee.	F4	95	3. Employees have received the approprientation and training prior to provid direct care to residents All new staff received the appropriate orientation properties and to care for staff. Complete 30-2015 4. An audit of personnel files will be conducted one (1) time per week time weeks, then monthly for one year to nothat all new staff have had the appropriorientation prior to providing direct of assure a system of assuring new employers the appropriate orientation prior to providing direct care. 5. The Director of Staff Development /designed will be responsible with overfrom the Administrator. Completion date of 12-31-2015.	have have lier to ed 12- s 12 conitor riate cre.	
F 496 SS=F	orlentation was not p 483.75(e)(5)-(7) NUR VERIFICATION, RET	SE AIDE REGISTRY	F 4	96	No residents were affected by the a deficient practice.	lleged	

Event lb: GY0H11

	OF BEHICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:		ING		(×	3) DATE SURVEY COMPLETED
		245227	B. WING				11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REH		1	1601 ST	ADDRESS, CITY, STATE, ZIP CODE LOUIS AVENUE H, MN 55802	1_	11110/2414
(X4) ID PREFIX TAG	(SACH ORFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	ID PREFI; TAG	(PROWDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION CIAZE
F 498	aide, a facility must in that the individual has requirements unless employee in a training evaluation program a individual can prove successfully complete competency evaluation program a has not yet been inclinated facilities must follow individual actually be Before allowing an imaide, a facility must a State registry establic (2)(A) or 1919(e)(2)(believes will include in training and competing and competing and competing individual provided in services for monetangind individual must competency evaluation. This REQUIREMENT by: Based on Interview a facility failed to ensure	individual to serve as a nurse receive registry verification as met competency evaluation the individual is a full-time ag and competency approved by the State; or the that he or she has recently ted a training and ion program or competency approved by the State and luded in the registry. If up to ensure that such an ecomes registered. Individual to serve as a nurse seek information from every shed under sections 1819(e) A) of the Act the facility information on the individual. It's most recent completion of othercy evaluation program, attinuous period of 24 during none of which the ursing or nursing-related by compensation, the other a new training and on program or a new	F	496			
ĺ	-	are to residents. This had all 159 residents residing in					1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFUX TAG	(EACH DEFICIENC	ATRIARNT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		(X5) COMPLETION DAT≐
F 496	working in the facility registry. Nursing ass included on the list provate checked with the A review of the schedworking with resident with another NA until schedule independent days between 10/31// During an interview of director of nursing (Dhow often the NA regional processing and the nursing certification had lapsed been working as a nutil HRD-I verified a regist to employment for NA During an interview of DON verified she was registration/certification and not been under of the time. During an interview of NA-M verified she had not been under of the time.	a list of all nursing assistants and who were on the state istant (NA)-M was not ovided by the facility that registry. Jules, indicated NA-M began is on 11/28/15, and worked 10/31/15. NA-M was on the try one to two shifts 14 of 19 15, and 11/18/15. In 11/18/15, at 7:41 a.m. the ON) stated she was not sure listry is checked. In 11/18/15, at 12:16 p.m. the ctor (HRD)-J verified NA-M grassistant registry and her and HRD-I stated NA-M had ursing assistant in the facility. After the check was not done prior and the sunaware that NA-M's an was not current until that ified NA-M had been assistant in the facility and irect supervision 100% of an 11/18/15, at 1:48 p.m. did been working as a nursing yand had provided cares to	F	496	 2. All residents have the potential to be affected by the practice. 3. NA-M is current with her certificat. All nursing assistant certifications have been verified as current. 4. An audit will be conducted each me for three (3) months and then quarterly one year to monitor that all nursing as certifications are current. The results audits will be presented to the monthly QAPI committee to assure that no nurses is that is allowed to provide direct of a resident without a current certificate. 	ion. ye onth y for sistant of the y rsing care to	

	OF DEFICIENCIAS CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1, ,		CONSTRUCTION		SURVEY PLETED
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER			16	REET ADDRESS, CITY, STATE, ZIP CODE		10,2010
			<u>l</u>	D	ULUTH, MN 65802		,
(X4) ID PREFIX TAG	(BACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) CGMPLETION DATE
F 496	Continued From page unsupervised.	105	F	196	 The Director of Human resources/designee will be responsible oversight from the Administrator. 	with	
F 498		-	į F4	198	Completion date of 12-31-2015.		
	COMPETENCY/CARI		'				
	to demonstrate competechniques necessary needs, as identified the	to care for residents!			 No residents were affected by the al- deficient practice. 	leged	
	by: Based on interview a facility failed to ensure annual education and education to maintain	d the potential to affect all					
	Findings Include:						
	nursing assistants (NA been hired in the past were scheduled to recorientation. The rema employed at the facility months, and had received training since 1/15: * NA-W had received a prevention/reporting a	ining NAs had been y for greater than 12 ived the following hours of 4.5 hours, including abuse nd general training. No evention or control, resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDSNTIFICATION NUMBER:	1 * * * * * *	ripLe canstruction NG		DATE SURVEY COMPLETED
		245227	B, WANG			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BIC PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	IVLD BE	(X5) COMPLETION DAITE
F 498	prevention/reporting a dementia, infection president rights, or prive mandatory training wat NA-Z had received include mandatory training, prevention/reporting, prevention or control, training, or other man * NA-C had received 9 prevention/reporting, indementia, resident right other mandatory training wat received prevention or control, training, or other man received. * NA-R had received include mandatory training, or other man * NA-P had received include mandatory training, or other man * NA-P had received abuse prevention/reporting, prevention prevention or control, training, or other man * NA-P had received abuse prevention/repinfection prevention or other man abuse prevention/repinfection prevention or other mandatory training, or other mandatory training, or other mandatory training, or other mandatory training, or other mandatory training, or other mandatory training, or other mandatory training or other	7.5 hours, including abuse and general training. No revention or control, racy training, or other as received. 1.0 hours, did not alining, such as abuse dementia, infection resident rights, privacy datory training. 5 hours, including abuse affection prevention. No also or privacy training, or any was received. 1.5 hours, including abuse ing. No dementia, infection resident rights, privacy datory training was 5.0 hours, did not alining such as abuse dementia, infection resident rights, privacy datory training. 8.5 hours, including orting. No dementia, r control, resident rights, her mandatory training. 6.5 hours, including orting. No dementia, r control, resident rights, her mandatory training. 8.5 hours, including orting. No dementia, r control, resident rights, her mandatory training. 8.6 hours, including orting. No dementia, r control, resident rights, her mandatory training.	F	498		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1		CONSTRUCTION		SURVEY PLETED
		245227	B. WING			11:	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	8 CTR	ID.	16	TREE I AUDRESS, CIFY, STATE, ZIP CODE 901 ST LOUIS AVENUE ULUTH, IMN 55802		["-
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI GROSS-REFERENCED TO THE APPROPRIA PEFICIENCY)		(X5) COMPLETION DATE
F 498	prevention/reporting a control. No demential training, or other man received. During an interview or director of nursing (Do training will be starting is hard to expect the a they are at work, so withey will be able to do for that. During an interview or registered nurse (RN) above had not receive training since at least of the previous training the NAs were to receive training since at least of the previous training unable to locate. RN-been offered over 22 I and had been offered throughout the year to RN-B stated she provious training. RN-B verified up on the status of each training. RN-B verified up on the status for each training. RN-B verified up on the status for each training. RN-B verified up on the status for each training, they had to do the employee had dor been included in the hard training they had to do the employee had dor been included in the hard training they had to do the employee had dor been included in the hard training they had to do the employee had dor been included in the hard training training they had to do the employee had dor been included in the hard training t	datory training. 5.5 hours, including abuse and infection prevention and resident rights, privacy datory training was 1.1/18/15, at 7:41 a.m. the DN) stated a new electronic groon. The DON stated it staff to attend training when with the electronic training. It at home and will get paid 1.1/18/15, at 8:30 a.m. B verified the staff listed at 12 hours of mandatory 1/15. RN-B was unaware greceived. RN-B stated we 12 hours of training sure of the mandatory, but had a list that she was B stated the NAs have hours of education this year, several opportunities obtain their 12 hours. Ided the nurse managers of employee and their did that she had not followed ach employee. RN-B stated and was offered in March, and an educational packet of the employee missed the or the make-up packet. If the the packet, it would have ours reported. RN-B stated to electronic training and	F	498	 All residents have the potential to be affected by the alleged deficient praction. Nursing assistants have received the hour mandatory training. An audit o will be completed each for three (3) months then quarterly for year to assure any nursing assistant requiring their 12 hour of mandatory education in a twelve month period of will have completed their mandatory training/education. 	ice. eir 12 month r one	

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	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER				(X3) DATE SURVEY COMPLETED			
		245227	B. WING			11/	11/18/2015	
	RDVIDER OR SUPPLIER	8 CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE OULUTH, MN 56802					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X8) COMPLETION DATE	
F 498	A facility policy for staff education was requested but not provided. 483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT		F	5. The Director of Staff F 498 Development/designee will be responsit with oversight by the Administrator.				
i			F	500	Completion date of 12-31-2015.			
V	If the facility does not professional person to to be provided by the have that service furn person or agency out arrangement describe Act or an agreement (2) of this section.	employ a qualified of furnish a specific service facility, the facility must lished to residents by a side the facility under an ed in section 1861(w) of the described in paragraph (h)			 No residents were affected by the aldeficient practice. All residents may have the potential affected by the practice. 			
	the Act or agreements furnished by outside r writing that the facility obtaining services tha standards and princip	les that apply to g services in such a facility;			3. An updated contract for Therapy we obtained by 12-1-2015	ns		
	by: Based on interview a facility failed to ensure therapy, occupational therapy was current.	Is not met as evidenced nd document review, the the contract with physical therapy, and speech This had the potential to s residing in the facility.			 All contracts will be reviewed quart at the QAPI committee to monitor that contracts remain timely and updated. (going. 	;		
	therapy, occupational	Agreement for physical therapy, and speech d 7/1/13, was between the						
	merapy services date	d 111/10, was between tite	1					

PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE	COMPLETED	
BAYSHORE RESIDENCE & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 500 Continued From page 109 previous owner of the facility and the therapy provider. F 500 Completed 12-31-2015.	/18/2015	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 500 Continued From page 109 previous owner of the facility and the therapy provider. F 500 Completed 12-31-2015.		
F 500 Continued From page 109 previous owner of the facility and the therapy provider. F 500 responsible, Completed 12-31-2015.	(XS) COMPLETION DATE	
the administrator verified the contract would have to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility. A policy for contract renewals was not provided. F 502 SS=C The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on Interview and document review the facility failed to ensure the contract for laboratory services was current. This had the potential to affect all 159 residents residing in the facility. Findings include: The facility did not have a signed contract for laboratory services to be provided for the facility. The letter of agreement dated 12/23/13, for services to be provided for the facility. The letter of agreement was signed by the laboratory provider only, and not by the facility. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the confract would have		

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STATEMENT AND PLAN OF						(X3) DATE SURVEY COMPLETED		
		245227	e. WING_			11/	18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF PEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMFLETION DATE	
F 502	Continued From page 110 o be updated. The administrator stated he would expect contracts would have been updated with he change in ownership. The administrator stated there had been no break in service for the residents residing in the facility. A policy for contract renewals was requested and		Fŧ	502	 4. The Laboratory contract will be reviguarterly in the QAPI committee to me the date of the contract. On going. 5. The Administrator/ designee will be responsible. Completion date of 12-31-2015. 	onitor		
	other diagnostic servi	OSTIC SVCS ide or obtain radiology and ces to meet the needs of its y is responsible for the	F.5	808	 No residents were affected by the a deficient practice. All residents have the potential to b affected by the alleged deficient pract 	e		
	by: Based on interview a facility failed to ensur services were current affect all 159 resident Findings include: The Imaging and Rac dated 12/2/09, was b the facility and the rac During an interview o the administrator veri to be updated. The a expect contracts wou the change in owners	n 11/18/15, at 12:51 p.m. fied the contract would have idministrator stated he would ld have been updated with hip. The administrator n no break in service for the			 3. The Radiology contract has made e 4. The radiology contract will be revie quarterly at the QAPI committee to m the date of the contract. On going. 5. The Administrator/designee will be responsible. Completion date of 12-31-2015. 	ewed onitor		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	Ð. WING	,		11	/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE . 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(SACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH GORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFIGIENCY)		(X5) · COMPRETION STATE	
F 514	483.75(i)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practic accurately documente systematically organiz The clinical record mulinformation to identify resident's assessment services provided; the preadmission screenin and progress notes. This REQUIREMENT by: Based on interview a failed to ensure accuracion completed for 5 of 5 re R76, R109) reviewed reviews. Findings include: R15's quarterly Minimi 9/11/15, included diag and dementia. The MI taking insulin, diuretics antianxiety medication R15's had an admission pharmacy consultant of the second size	tain clinical records on each ewith accepted professional es that are complete; ed; readily accessible; and red. Instructions sufficient are conducted by the State; is not met as evidenced and record review, the facility ate medical records were asidents (R15, R38, R61, for monthly pharmacist and poses of diabetes mellitus of indicated R15 had been a antipsychotic and		508 514	 No residents were affected by the affected practice. All residents have the potential to be affected by the practice. The pharmacy consultant reports winow be individualized and filed in the residents chart. An audit will be completed each me for three (3) months to monitor the pharmacy consultant reports /recommendations have been filed in the resident's chart. These audits will be presented to the monthly QAPI committee will make a recommendation as to the need to contate to monitor that the Consultant pharmac reports are being filed in the residents' chart. The Director of Nursing/designee were sponsible with oversight from the Administrator. Completion date of 12-31-2015. 	e ill ittee he iinne		

	OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIFRACIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		246227	B. WING			11/	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			16	REET ADDRESS, CITY, STATE, ZIP CODE 61 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEPICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X6) COMPLETION DATE
F 514	diagnoses of diabete The MDS indicated R and antipsychotic me R38 had an admission pharmacy consultant review for January, F. May, June, July, Augit October 2015, were r. R61's admission MDS diagnoses of depression had been taking an antipsychotic review for January, F. May, June, July, Augit October 2015, were r. R76's quarterly MDS diagnoses of dementification and post in disorder. The MDS in taking antipsychotic r. R76 had an admission pharmacy consultant review for January, F. May, June, July, Augit October 2015, were r. R109's quarterly MDS diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses.	dated 10/26/15, Included as mellitus and dementia. 38 had been taking insulin dications. In date of 4/1/13, the verification of medication abruary, March, April, lust, September and atted 10/29/15, Included on. The MDS indicated R61 tildepressant medication. In date of 4/11/13, the verification of medication abruary, March, April, lust, September and atted in R38's chart. In dated 8/13/15, included at anxiety disorder, traumatic stress dicated R76 had been medications. In date of 10/16/09, the verification of medication abruary, March, April, lust, September and medication of medication abruary, March, April, lust, September and not filed in R38's chart. In dated 9/14/15, included isorder, depression,	F	514			
	dementia and a psychol indicated R109 had tak	otic disorder. The MDS ten antipsychotic.					

	OF DESICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDÉNTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B:WING			11	11/18/2015	
	ROVIDER ÖR SUPPLIER RE RESIDENCE & REHA	B CTR	STREET ADDRESS, CHY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802					
(X4) ID PRESIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (FACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 519	R109 had an admissic pharmacy consultant review for January, Fe June, July, August, Se 2015, were not filed in During interview on 11 assistant director of me pharmacy consultant I with the October 2015 medication review ver were now individualized were kept in the ADOI Individual resident's medication review ver previously sent via enresident's medical received to contact the conprovide documentation review's prior to October 2015.	epressant medications. In date of 11/11/14, the verification of medication abruary, March, April, May, eptember and October 1838's chart. In 18/15, at 9:44 a.m. the ursing (ADON) stated the had started a new process in pharmacy consultant's ification forms. The forms and by resident and they N's office in a file, not in an edical record. The ADON pharmacy consultant's lification forms were mail and were not filed in the lord. The ADON verified she isultant pharmacist to not the medication per of 2015. Cords was requested and	F 5	514	 No residents were affected by the a deficient practice. All residents have the potential to be affected by the practice. The pharmacy consultant reports we now be individualized and filed in the residents chart. An audit will be completed each me for three (3) months to monitor the pharmacy consultant reports /recommendations have been filed in tresident's chart. These audits will be presented to the monthly QAPI comm for three months. The Director of Nursing/designee were sponsible with oversight from the Administrator. Completion date of 12-31-2015. 	e ill onth he		
	In accordance with sec facility (other than a nu- focated in a State on a have in effect a written one or more hospitals under the Medicare an reasonably assures that transferred from the fa	in Indian reservation) must transfer agreement with approved for participation and Medicaid programs that			 No residents were affected by the alpractice. All residents have the potential to be affected by the practice. 			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUDENTIFICA TION NUMBER: A BUIL				CONSTRUCTION		(XS) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		•	160	REET ADORESS. CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JEUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y WUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(D PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) GOMPLETION DATE	
F 519	by the attending physinformation needed for residents, and, when deems it appropriate, such residents can be less expensive setting the hospital, will be elimitated in agreement in effect it good faith to enter in hospital sufficiently contrained from the facility failed to ensure at least one hospital potential to affect all facility. The Transfer Agreement hospital facility. The Transfer Agreement hospital facility. The Transfer Agreement hospital facility. During an interview of administrator verified be updated. The administrator verified be updated. The administrator would be updated in owners.	appropriate, as determined sician; and medical and other or care and treatment of the transferring facility, for determining whether e adequately cared for in a githan either the facility or exchanged between the sered to have a transfer of the facility has attempted in the an agreement with a lose to the facility to make of its not met as evidenced and document review, the relative a transfer agreement with the serious current. This had the serious current approvider. The serious the facility and the serious and hospital provider. The serious the facility and the serious and hospital provider. The serious the facility and the serious and hospital provider. The serious the facility and the serious and hospital provider. The serious the facility and the serious the serious for the se	F	519				

	OF DEPICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER,	1		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245227	B. Wing		****	11	/18/2015	
	ROVIDER OR SUPPLIER	BCTR		16	TREET ADDRESS. CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATRIMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) CXMPLETION DATE	
F 519	Continued From page A policy for contract o not provided.	agreement renewals was	F	519	3. The hospital transfer agreement has updated. These will be reviewed quart to monitor compliance. On going. 4. The Administrator /designee will be responsible. Completion date of 12-31-2015.	terly		
						- 1		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l'''	IPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
		245227	B. WING_	·		11/	18/2015
	ROWDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADORE 1801 ST LOUIS DULUTH, MIN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	IP PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ne	(X5) COMPLETION DATE
	you allegation of complete the first page be used as verification. Upon receipt of an accrevisit of your facility realled that substantingulations has been your verification. An investigation of concompleted. The completed. The completed survey was Initiated did Jeopardy at F323. The removed on 11/18/20° The survey resulted in (IJ) at F323 related to comprehensively a implement intervention risk of falls with serious who had frequent falls. The immediate jeopart 11/18/15, at 10:30 a.m. the facility effectively in plant.	nce. Your signature at the period of the CMS-2567 form will in of compliance. ceptable POC, an onsite may be conducted to ial compliance with the attained in accordance with implaint #H5227054 was laint was unsubstantiated. In 11/12/2015, an extended up to an Immediate de Imm	OF NO		No residents were affected by the alleged		
SS≒E	PERSONAL FUNDS	BOND - SECURITY OF	F 10	71	deficient practice.		
APCIDATION OF	HOSPITADIS OR DROVIDGOS	OPPLIER REPRESENTATIVE'S SIGNATURE			TITI E		

Any deficiency statement anding with an esteriak (*) 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 regulate to continued program participation.

FORM CMS-2597(02-99) Previous Versions Obsolete Event ID: CYÚH11 Facility ID: 00689 If continuation sheet Pago 1 of 116

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PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	. (X1) PROVIDER/BUPPLISR/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		245227	B. WING	MN Dept of Hazilh	11/18/2015
NAME OF PE	ROVIDER OR SUPPLIER		1 9	STREET ADDRESS, CFTY, STATE, ZIP CODE	
			1	601 ST LOUIS AVENUE	
BAYSHOR	RE RESIDENCE & REHA	B CTR	[DULUTH, MN 55802	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	you allegation of complete the first page be used as verification. Upon receipt of an acceptate of your facility is validate that substant regulations has been your verification. An investigation of completed. The completed. The completed. The completed arrively was initiated of Jeopardy at F323. The survey was initiated of Jeopardy at F323. The survey resulted in (IJ) at F323 related to comprehensively a implement intervention risk of falls with serious who had frequent falls. The immediate jeopa 11/18/15, at 10:30 a.r. the facility effectively plan.	ince. Your signature at the je of the CMS-2567 form will in of compliance. Inceptable POC, an onsite may be conducted to list compliance with the attained in accordance with implaint #H5227054 was obtain was unsubstantiated. Inceptable POC, an onsite may be conducted to attained in accordance with implaint #H5227054 was obtain was unsubstantiated. In an immediate of an immediate me immediate Jeopardy was 15. In an immediate Jeopardy was 15. In an immediate Jeopardy was in order to minimize the us injury or death for R61 is.	F 161	The Plan of Correction constitutes Bayshore Residence and Rehabilitation Center's written compliance for the deficiencies cited. However, the submission of this Plan of correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law.	
	PERSONAL FUNDS	DOMO - SECURITY OF	F 101	donosai praence.	
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	.E	TITLE	(XU) DA)E
	7 Yaki /S	1337	مراجع والمنابع	~1~~ /	2-17-2015

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.

FÖRM CMS-2567(02-88) Previous Versions Obsolete

Event ID: GYQH91

Facility IO: 00589

If confinuation sheet Page 1 of 116

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION DENTIFICATION NUMBER: A. BUILDING					(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11.	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	AB CTR		STREET ADDRESS, GTY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
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F 161	otherwise provide as Secretary, to assure	e 1 chase a surety bond, or surance satisfactory to the the security of all personal posited with the facility.	F	161	Residents may have the potential affected by the alleged deficient properties. The facility purchased a new Sur Bond November 17, 2015, which could the amount in the resident trust fundament.	ectice. rety overs	
	by: Based on observation review, the facility fail bond was sufficient to the resident fund acc	F is not met as evidenced on, interview, and document led to ensure the surety o cover the total amount in counts. This had the potential is and current residents who			4. The facility will monitor the resi trust fund every month for three (3 months to monitor the Surety Bond the resident trust fund balance. If il would be a negative occurrence, th facility will take immediate action the trust fund balance.) l covers nere e	
	that protects the resifund account held by amount of the surety of the resident funds. The surety bond data resident personal fur total of \$39,000. The facility trust fund 11/11/15, indicated 1 in the facility or who facility—had an open	ed 10/24/13, Indicated the ods were protected up to a balance report dated 139 residents who now reside previously resided in the trust fund account for a total			5. The results of the audits will be to the monthly QAPI committee for months. 6. The Administrator/designee will	r three	
	money in the trust fu sufficient to secure to by the facility. During an interview of	f 159 current residents had nd. The surety bond was not he total resident monies held on 11/17/15, at 3:15 p.m. the			responsible.		

	001111	(X3) DATE SURVEY COMPLETED		
245227 B. WNG	11/2	18/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 65802	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD FAR CROSS-REFERENCED TO THE APPRINT DEFICIENCY)	DULD BE	(X5) COMPLETION CATE		
The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personel funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the surety bond was sufficient to cover the total amount in the resident fund accounts. This had the potential to impact 83 previous and current residents who had money in the account. Findings include: A review of the facility's surety bond (insurance that protects the resident personal funds in trust fund account held by the facility), revealed the amount of the surety bond was less than the total of the resident funds held by the facility. The strety bond dated 10/24/13, Indicated the resident personal funds were protected up to a total of \$39,000. The facility trust fund balance report dated 11/11/16, indicated 139 residents who now reside in the facility thad an open trust fund account for a total of \$38,829.27. 83 of 159 current residents had money in the trust fund. The surety bond was not sufficient to secure the total resident monies held by the facility. During an interview on 11/17/16, at 3:15 p.m. the administrator verified the surety bond was not	surety ch covers fund. The week I balance, will monitor each week the Surety und balance, distrator action to reported to or three QAPI condation as for that the ident trust			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTIO	(X3) DATE SURVEY COMPLETED			
		245227	B. WING_	B. WING			11/18/2016	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS 1801 ST LOUIS A DULUTH, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACI	COVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIAT DEFICENCY)		(X5) GDMFLSTI(XN DATE	
	sufficient to cover the The facility policy and Trust Account dated bond would be maintered account and would be maintered account and would sale account and would sale account and would sale account and would sale account and would sale account and would sale account and the confidentiality of his confidentiality of his confidentiality of his confidentiality of his confidentiality of his confidentiality of his confidentiality of his confidentiality of his confidential records. Personal privacy included in the resident account account family and does not require the from a provided in section, the resident account and clinical records does not record account and clinical records does not resident account and clinical records does not record account and clinical records does	resident fund balance. I procedure for Resident I/2015, indicated a surety ained on the resident trust Uld be renewed annually I) PERSONAL NTIALITY OF RECORDS right to personal privacy and or her personal and clinical udes accommodations, ritten and telephone sonal care, visits, and of resident groups, but this facility to provide a private int. I paragraph (e)(3) of this may approve or refuse the ind clinical records to any facility. I refuse release of personal des not apply when the I to another health care release is required by law. I confidential all information lent's records, regardless of methods, except when I transfer to another I law; third party payment	F	1. F ti d 2. A	Resident #46 was not affecte the alleged deficient practice documented by Social Service. All residents have the potent peing affected by the alleged deficient practice.	as ces. ial for		

AND PLAN OF CORRECTION IDENTIFICATION MINRED		1''	LTIPLE CONSTRUCTION (X3) DATE SUF					
		245227	B. WING			11.	/18/2015	
BAYSHOF (X4) ID		ATEMENT OF DEFICIENCIES	ID PRESIVE					
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR I Continued From page This REQUIREMENT by: Based on observation review, the facility failt privacy during a pain a pass for 1 of 1 resider privacy. Findings include: R46's Admission Recoincluded chronic kildned diabetes, and chronic quarterly Minimum Da indicated R46 was considered at 11/13/15 oxycodone every four On 11/12/15, at 8:55 a aide (TMA)-B was obsected in the hallway. W TMA-B called loudly, " who was in his room w be heard by any reside in the hallway. When asking about R46's pa TMA-B replied, "I guest explain R46 is hard of In an interview on 11/1 registered nurse (RN)- expected ficensed stat privacy. RN-A continu- nurse would go into a	ATEMENT OF DEFICIENCIES WINDST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 3 is not met as evidenced In, interview and document and to maintain resident assessment/medication als (R46) reviewed for ord identified diagnoses that ay disease stage 4, type 2 paln due to trauma. The ala Set (MDS) dated 9/4/15, gnitively intact and received ations. The physician's a, directed R46 to receive hours, as needed, for paln. a.m., trained medication between at the medication hile standing at the cart, What's your pain?" to R46, with the TV on. This could ent, staff or visitor who was asked if this method of in maintained privacy, as not", and continued to hearing so she had to yell. 13/15, at 9:52 a.m.,	PREFIX TAG			ent's ed ed s to sting a ve staff d to ew. f to good	(X5) COMPLETION DATE	
	stated if the resident w even more reason for resident's side.	ere hard of hearing, that is the nurse to be at the				:		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		(X3) DATE SURVEY GOMPLETED			
		245227	a. WING_			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PRESIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XB) COMPLETION DATE
F 166	5/11, directed staff wiregarding their condit addition, the facility's policy, dated 10/14, divoice when discussing information or move to 483.10(f)(2) RIGHT TRESOLVE GRIEVAN A resident has the rigit facility to resolve griethave, including those of other residents. This REQUIREMENT by: Based on interview a facility falled to ensuring rievances, and feed residents (R42), reviewalled quadriplegial depression, and anxiom mum Data Set (Not indicated intact cogniting and personal hygiene 10/4/13, Indicated R4 injury/abuse due to mot become a targereceive injuries from a serial serial procession and a stargereceive injuries from a serial procession and appropriate transfers.	Privacy undated, reviewed in II speak with residents ions in a private area. In HIPAA and Confidentiality irected staff to lower their g protected health of a private area. O PROMPT EFFORTS TO CES In the prompt efforts by the vances the resident may with respect to the behavior with respect to the behavior is not met as evidenced and document review, the eleprompt resolution of back to residents, for 1 of 1 ewed for grievances. In Indicated diagnoses that the type 2 diabetes, ety. R42's quarterly IDS) dated 9/25/15, tion. The MDS also dextensive assistance for y, dressing, eating, toileting at R42's care plan dated 2 was at risk for nobility deficits, with the goal et of abuse, retaliation or another. Interventions or psychological, emotional	F 1		1. Resident #42 stated to the Director Social Services that he was not affect the alleged deficient practice. Weekly meetings between Social Services and resident # 42 have been initiated. 2. All residents have the potential to laffected by the alleged deficient practice. The Administrator and Director of Services reviewed and revised the Poregarding Resident Concerns. The Porevised to include documentation that resident has been informed of the investigation and resolution of the co. The Administrator and Director of Services will review all resolutions.	of ed by d d Social licy olicy is t the	

245227 B. WING	8/2015
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	
(X4LID SUMMARY STATEMENT OF DESIGNATION ID PROVIDENCE ALABOR COORDESTION	
BOTTIN (FLOUR PROPERTY AND THE PROPERTY	(X5) COMPLETION DATE
In an interview on 11/9/15, at 6:03 p.m., R42 stated he has made multiple complaints about a specific nursing assistant (NA) being very loud at night. R42 said every night this NA works, he gets woken up. R42 stated at the supper meal he just left, line NA didn't ask him a question directly, but asked another staff person to ask R42 a question. R42 stated this "attitude" all started when he made a complaint. In the Interview, R42 stated the facility social worker has said they're doing something about noise at night, but nothing has changed. R42 has requested that a NA not care for him, but has been told that the NA can't be taken off the unit and that if he won't have the NA in his room, then his cares won't get done. During the interview, R42 said he was done complaining because all that happens is more attitude from nursing assistants. R42 said that when he recently complained, a nurse wrote up a behavior incident on him and then the nurse practitioner asked if he wanted to re-start antidepressant medication. R42 stated he is worried that if he says anything, he'll have to go back on his antidepressant. In an interview on 11/13/15, at 11:07 a.m., the social service director (SSD) stated when a complaint is filed, they notify the Director of Nursing and the administrator; they report to the state agency if necessary, and make sure the resident is safe. Ultimately, the written completes the follow-up and coordinates work with the appropriate department. The SSD stated residents can were taking and staff can	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILO		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	•	160	EET ADDRESS, CITY, STATE, ZIP CODE 1 ST LOUIS AVENUE LUTH, MIN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFU TAG	ς	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMFLETION DATE
F 166	department tracks col- quality assurance (Q/ residents are care plate accusations about state investigates. The faciliafter a pattern is iden. During the 11/13/15, is SSD stated that R42 staff person work with maybe in June. The Sthese requests and the NA does not normally people are needed the unless R42 "says no." In an interview on 11/2 stated he did talk to the unit's nurse manable his concerns of loud if they did tell him they has gotten no other in of the grievance. In an interview on 11/2 stated the facility has typically begins with off the grievance. In an interview on 11/2 stated the facility has typically begins with off the grievance. SSD stated she had in 10/22/15, by R42 of in she talked to the night SSD stated the night.	ce form. The social services implaints and reports to A). The SSD stated some inned for making false off, but the facility still lity will care plan this only tified with a resident. at 11:07 a.m., interview, the did request to not have a him, a long time ago, as D stated R42 will make the change his mind. The work with R42, but If two is NA will come to assist, and facility social worker and ager more than once about NA's at night. R42 stated are "working on it" but he atomation about the status of 18/15, at 8:03 a.m., SSD a grievance process that completion of a complaint report orally, but they prefer ecause it is better for SD stated social services aints and kept a log of received one complaint on toise at night. SSD stated at nurse about the complaint.	F	166			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDII	SURVEY PLETED					
		245227	B. WING_			11/	11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA SUMMARY STA			16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802			
PREFIX TAG	(EACH DEFIÇIEND)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				(XS) COMPLETION DATE	
F 225 SS=D	it is their day, but it is stated when she arrivicheck in with the night of the ordinary. SSD singht nurse about nots have not audited night not received any other regarding noise or oth. The facility resident or 5/2/15, directed concerns will be invessionable of the complainant. The poconcerns will be invessionable of the complainant. As 13(c)(1)(ii)-(iii), (c) INVESTIGATE/REPO ALLEGATIONS/INDIVITHE facility must not eleven found guilty of almistreating residents I had a finding entered in registry concerning about report any knowle court of law against ar indicate unfitness for sother facility must ensure including injuries of unmisappropriation of residents or misappent and report any knowle court of law against ar indicate unfitness for sother facility staff to the or licensing authorities. The facility must ensure including injuries of unmisappropriation of residents of residents or misappents of unmisappropriation of residents of unmisappropriation of unmisappropriation of unmisappropriation of unmisappropriation of unmisappropriation of unmisappropriation of unmisappropriation of unmisappropriation of unmisappropriation of unmisappropriation of u	thight, acknowledging that the resident's night. SSD and in the morning, she will thurse if anything was out stated she has not asked the selevet recently and they thoise. SSD stated she had recomplaints from R42 are concerns. Incomplaints from R42 are concerns and the written or licy further directed all tigated and resolved within enuating circumstances and to and are acceptable. Incomplete the from the first from the state nurse aide use, neglect, mistreatment repriation of their property; dge it has of actions by a memployee, which would service as a nurse aide or a state nurse aide registry in that all alleged violations to neglect, or abuse, are that all alleged violations to neglect, or abuse,	F 1	166	4. All resident concerns and the resoluthat those concerns were presented to resident will be reported at the month! QAPI meeting for (3) three months. A three months the QAPI committee will make a recommendation as to the need continue to monitor that the facility in the resident of the investigation and resolution of those concerns. 5. The Director of Social Services /desi will be responsible with oversight by the Administrator. Completion date of 12-2015. 1. Residents # 96 and #90 were not affine by the alleged deficient practice. Social Services has initiated weekly meetings resident # 90. Two staff members will assigned to provide cares to resident #92. All residents have the potential for that affected by the deficient practice.	the y fter l to forms ignee he 31- ected l with be 96.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245227	B. WING			11/18/2015		
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		•	STREET ADDRESS. CITY, STATE, 29 1601 ST LOUIS AVENUE DULUTH, MN 55802	PCODE			
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSG IDENT:FYING INFORMATION)	ID PREFØ TAG	PROVIDER'S PLAN DI ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	(X5) COMPLETION DATE		
F 225	through established p State survey and cert The facility must have violations are thoroug prevent further potent investigation is in pro- The results of all inve- to the administrator of representative and to with State law (includi- certification agency) to incident, and if the all	cordance with State law procedures (including to the ification agency). e evidence that all alleged thly investigated, and must tial abuse while the gress.	F					
	by: Based on Interview a facility failed to immed potential mistreatmer and thoroughly invest mistreatment for 2 of reviewed for potentia Findings include: R90 stated he had be staff member, he had and the facility told hi about it unless he put R90's quarterly Minim 9/14/15, identified dia cerebral vascular acc	een verbally abused by a reported it to the facility, m they couldn't do anything tit in writing.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDE	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		. '	STREET ADDRESS, CITY, STATE, ZIP 1601 ST LOUIS AVENUE DULUTH, MN 55802	CODE	
(X4) IĐ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT: CROSS-REFERENCED TO TO PREFICIENCE	ION SHOULD BE HE APPROPRIAT	
	required extensive stamobility, personal hygplan dated 1/8/14, Indicatheter at night, and assistance every two. On 11/10/15, at 12:45 ago) his condom cathin hight. Nursing assistance angry. NA-Nito change him if he bedescribed her behavior R90 stated he reporte following day. On 11/1 member (F)-A stated in NA-N's verbal abuse the F-A stated they report (RN)-G, who told then verbal abuse by a star writing, or the facility wabout it. On 11/12/15, at 7:10 at (DON) verified there were for R90's report of verbal abuse there are ported if to the DON DON or the social wor fill out a grievance for nursing assistant amio complaint had to be in resident. At 5:48 p.m.	s continent of urine, and aff assistance with bed jiene and toiteting. The care icated R90 used a condom used the urinal with staff hours and as needed. i. p.m. R90 stated (a while eter had come off during istant (NA)-N came into his sked her to leave the ne would use the urinal, she stated she didn't have time ecame wet (with urine). R90 or as loud, rude and snotty. If the following day, and to staff the following day, as the resident's report of the member must be put in was unable to do anything a.m. the director of nursing was no mistreatment report ball abuse by NA-N. I. m. RN-G was interviewed abored R90 and F-A by NA-N. RN-G stated she and was told either by the ker R90 that F-A needed to m. RN-G further stated the n was strong, and a	F	225		

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245227 NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DIVIDITE ANN ESPACE			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE	3/2015		
DULUTH, MN 55802	DOE		
	(XS) COMPLETION DATE		
F 225 On 11/12/15, at 5:52 p.m. the DON was interviewed, and stated R90 and F-A filled out a grievance form regarding allegad verbal abuse by NA-N. The DON stated she did not report R90's allegation of verbal abuse to the state agency, and she did not trivestigate. "It was a "he said she said" "the DON verbalized. "I have a union here," and she instructed NA-N not to go into R90's room again. On 11/13/15, at 2:10 p.m. the director of human resources (HR)-I stated she did not receive a grievance form completed by R90 and F-A, and there was no documentation in NA-N's file indicating any type of discipline regarding R90's complaint of afleged verbel abuse. On 11/13/15, at 2:16 p.m. the director of social services (SW)-B stated she did not have a grievance form completed by R90 and F-A. On 11/13/15, at approximately 2:15 p.m. the facility provided a copy of R90 and F-A's grievance form. The grievance form was dated 7/29/15, and indicated the following: "Resident's (sic) rang for staff on NOC (night) shift to come in as condom catheler was falling off. Staff (NA-N) was CNA (certified nursing assistant). Resident asked to have condom cath removed and he would use urinal rest of night, Staff responded 'no, I don't want you to piss the bed' and dermanded resident have condom cath put back on." The form was signed by RN-G and dated 7/30/15, and the DON and administrator were notified on 7/30/15. The facility policy and procedure on Abuse Prevention Plan undated, directed the administrator must be informed immediately of all			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245227	B, WING			1 11	/18/2015		
_	PRÉFIX (EACH DEFIC	•	TATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE						
	verbal abuse as ti gestured languag disparaging or de their families. The incidents are to be investigated intere 2. R96 had diagnose low back pain, ge Minimum Data Se identified R96 had required extensive person for activitie MDS also identified R96's care plan de "Resident is a vult injury/abuse from Potential for relati Disorder. Resident saway." Also "[R96 verbally abusive be intervention to this choloes as possib An Interview on 1 said "One time I wassistant. I was si sweater on. She verbally and their intervention to but a fractured my thum hurting me she sa	rise Prevention Plan defined the use of oral, written or a that willfully includes rogatory terms to residents or policy further directed that all a reported, documented and hally. It is of physiological condition, meralized arthritis. The quarterly it (MDS) dated 10/19/15, I no cognitive impairment and a limited assistance from one as of daily living (ADL)'s. The id R96 as having no behaviors. The deficit also noted to give money I has potential to demonstrate the ehaviors." An applicable is was to give R96 as many let. If 10/15, at 12:50 p.m. R96 has abused. It was a nurse thing on the toilet with my wanted to take the sweater off she took it off anyway. She b. When I told her she was id 'I don't give a fuck'. I told is gone as long as my thumb		225 Eacl	3. Staff were inserviced on the A Neglect, and Mistreatment Polic Administrator reviewed the polic procedure with the Director of services and the DON reviewing them the procedures and expect for a thorough investigation. The Administrator directed the Direct Social Services to resume primar responsibility for conducting the investigation relating to any allegor abuse, neglect or mistreatment will be reported to the proper State age.	y. The cy and octal with cations of y gation of octal attornations of y gation of octal attornations.	ag⊭ 12 of 116		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			16	TREET ADDRESS, DITY, STATE, ZIP CODE NOT ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH PEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	IJ PREFIX TAG		PROVIDER'S PLAN DE CORREC'I'ON (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 225	hurting me. Everyone need to be treated like. An Interview on 11/12 director of nurses (DC them different events R96 had a "tussle" in this event. The DON sa reported nursing assis finger. The DON said away but did not have regarding this issue. The report dated 06/3 resident was interview by this writer. She toke each time. She had for the day prior to the regrabbed something froshe had complained of Bruise is healing. The staff in question without a staff in question wit	that knows me know I don't that knows me know I don't that knows me know I don't that knows me know I don't that knows me know I don't that knows me know I don't that I cooperate". /2015, at 1:50 p.m. the low provided that had happened to her that had happened to her that said no other staff received in the next day R98 stant (NA)-T grabbed her she investigated it right to a through investigation 0/15, indicated "The red several times, including that another resident that another resident to me that same hand and that the port that another resident of the ing the resident's hand. She was also interviewed by this there was no incident of the ing the resident refused to dx [diagnosis] and has seeds staff supervision for sono findings of abuse In this lotion "The resident reports and that an aide last I during cares. Employee livestigation, and care can so in the room during cares.	F	225			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245227	B. WING			11	/18/2015	
	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 226	11/17/15, at 11:13 a.m abuse to us regularly, correlation between making reports of abu. An interview on 11/17, social services (SS)-B completing the vulner months to a year. SS-nursing at that time, be was being transitioned department again. SS do with R96's VA repositivestigation. An interview with DON p.m. said she does not investigation of the brothis is a she said/she sidlagnoses that make it. A final radiology repor "There are likely dege however small avulsed completely excluded". A physician office visit "There is dark purple of then areminence, the vithumb".	stered nurse (RN)-A on in said she (R96) reports RN-A said there is a of R96 getting her way and se. /2015, at 11:25 a.m. with slated she hasn't been able adult (VA) report for 9 B said it was transitioned to ut in the last couple weeks to be be be been able and services. B said she had nothing to out from July or the lone of the following the said she had nothing to out from July or the last and R96 has a lot of the unreliable. It dated 7/1/15, indicated the active in etiology, if fracture fragment is not dated 7/8/15, indicated ecchymosis present on the rolar wrist, and the dorsal services. MPLMENT		225	4. All allegations – and the investigat of abuse, neglect and mistreatment w presented to the QAPI monthly meeticevery month for three (3) months to monitor the thoroughness of the investigations. After three months the QAPI committee will make a recommendation as to the need to mothat the facility has properly investigated and reported all alleged abuse, neglector mistreatment. 5. The Director of Social Services/detwith oversight from the Administrator be responsible. Completion date of 12-31-2015. 1. Residents # 96 and #90 were not affected by the affected deficient praces social services has initiated weekly meetings with Resident #90. Two staffmembers will be assigned to provide a to resident #96.	ill be ng nitor ted et and ignee will		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(KZ) MULTIPLE CONSTRUCT:ON A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245227	B. WING,	B. WING		11/	18/2015
	ROVIDER OR SUPPLIER	B CTR		STREET ADDRESS, CITY, STATE, ZIP COSE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	\$UM\$ARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XB) COMPLETION DATE
F 226	Continued From page 14 The facility must develop and Implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.		F 226		All residents have the potential for affected by the alleged deficient pract	_	
	by: Based on observation review, the facility fail policy to ensure immedilegations of potential Agency (SA) and thousallegations of potential	al mistreatment to the State			3. Staff were inserviced on the Abuse, Neglect, and Mistreatment Policy. Completed 11-18-2015. The Administ reviewed the Mistreatment Policy and Procedure with the Director of Nursin the Director of Social Services and the procedures and expectations for a thor investigation. The Administrator direct the Director of Social Services to resuprimary responsibility for conducting investigation relating to any alleged a neglect and or mistreatment. Complet 4-2015.	trator g and cough sted me the buse,	
	R90 stated he had been verbally abused by a staff member, and the facility failed to report to the SA, and thoroughly investigate. The facility policy and procedure on Abuse Prevention Plan undated, directed the administrator must be informed immediately of all incidents. The Abuse Prevention Plan defined verbal abuse as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or their families. The policy further directed that all incidents are to be reported, documented and investigated Internally. R90's quarterly Minimum Data Set (MDS) dated 9/14/15, identified diagnoses that included cerebral vascular accident (CVA, commonly				 4. All allegations and the subsequent investigations will be presented at the monthly QAPI meeting for three mon monitor that the faculty followed its F on Mistreatment. After three months to QAPI committee will make a recommendation as to the need to most that the facility has properly investigated and reported all alleged abuse, neglect of mistreatment. 5. The Director of social services with oversight from the Administrator will responsible. Completion date of 12-3- 	ths to folicy he nitor ted at and	

	TEMENT OF BEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED	
	•	245227	B. WING	·		11/18/2015
	ROVIDER OR SUPPLIER		:			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE LSC DENTIFYING INFORMATION) TAG CROSS-REFERENCED		N OF CORRECTION (X5 É ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT CIENCY)	
	required extensive stamobility, personal hygplan dated 1/8/14, indicatheter at night, and assistance every two. On 11/10/15, at 12:45 ago) his condom cathine night. Nursing assistance angry. NA-N to change him if he behavior as loud, he reported NA-N's veday. On 11/12/15, at 16(F)-A stated she went verbal abuse to staff they reported to regist told them a resident's staff member must be was unable to do anyt. On 11/12/15, at 7:10 a (DON) verified there were for R90's report of verborted it fo the DON DON or the social wor fill out a grievance for nursing assistant union complaint had to be in resident. At 5:48 p.m.	s continent of urine, and aff assistance with bed alene and toileting. The care icated R90 used a condorn used the urinal with staff hours and as needed. i. p.m. R90 stated (a while eter had come off during alstant (NA)-N came into his sked her to leave the ne would use the urinal, she stated she didn't have time acame wet. R90 described rude and snotty. R90 stated erbal abuse the following 12:24 p.m. family member with R90 to report NA-N's he following day. F-A stated ered nurse (RN)-G, who report of verbal abuse by a put in writing, or the facility hing about it. a.m. the director of nursing was no mistreatment report ball abuse by NA-N. b.m. RN-G was interviewed abered R90 and F-A by NA-N. RN-G stated she and was told either by the ker R90 that F-A needed to m. RN-G further stated the news strong, and e	FZ	226		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(XS) DATE SURVEY COMPLETED		
		245227	B. WING	B. WING		11/	11/18/2015	
	ROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP CI 1601 ST LOUIS AVENUE DULUTH, MN 55802	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OUTICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIA		(XS) COMPLETION DATE	
F 22 6	On 11/12/15, at 5:52 Interviewed, and state grievance form regard NA-N. The DON state allegation of verbal at and she did not invest said! " the DON verband she instructed Naroom again. On 11/13/15, at 2:10 resources (HR)-I stat grievance form compitere was no docume indicating any type of complaint of alleged at 2:16 p.m. the direct (SW)-B stated she diccompleted by R90 and On 11/13/15, at apprefacility provided a congrevance form. The grievance form. The grievance form the grievance form the sacondom catheter was CNA (certified in asked to have condowould use urinat rest ino, I don't want you it demanded resident hor." The form was sig 7/30/15, and the DOI notified on 7/30/15.	p.m. the DON was ed R90 and F-A filled out a ding alleged verbal abuse by ed she did not report R90's buse to the state agency, digate. "It was a 'he said she atized, "I have a union here," A-N not to go into R90's p.m. the director of human ed she did not receive a leted by R90 and F-A, and entation in NA-N's file of discipline regarding R90's everbal abuse. On 11/13/15, eter of social services d not have a grievance form and F-A. eximately 2:15 p.m. the early of R90 and F-A's grievance form was dated d the following: "Resident's NOC (night) shift to come in was falling off. Staff (NA-N) ursing assistant). Resident m cath removed and he of night. Staff responded to piss the bed' and have condom cath put back gned by RN-G and dated N and administrator were	F	226				
	back pain, generalize Minimum Data Set (N	ed arthrills. The quarterly ADS) dated 10/19/15,						

STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245227	B. WING			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP COI 1601 ST LOUIS AVENUE DULUTH, MN 55802	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (BACH DEFICIENCY MUST BE PRECEDED BY FULL PREF REGULATORY OR LSC (DENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF GOI (IBACH CORRECTIVE ACTION GROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 226	required extensive limperson for activities of MDS also Identified R An interview on 11/10 "One time I was abus I was sitting on the tole wanted to take the swishe took it off anyway. When I told her she widon't give a fuck'. I tole as long as my thumber much of a penalty for knows me know I don't active of a nurses (DC them different events had a "tussie" in the srevent. The DON said report. The DON said nursing assistant (NA) DON said she investig not have a through invisue. The report dated 06/3 resident was interview by this writer. She told each time. She had for the day prior to the regrabbed something froshe had complained of Bruise is heafing. The staff in question witer, and stated that	cognitive impairment and litted assistance from one if daily living (ADL)'s. The 96 as having no behaviors. 115, at 12:50 p.m. R96 said ed. It was a nurse assistant, let with my sweater on. She reater off and I said no but . She fractured my thumb. as hurting me she said 'I deveryone, she was gone was healing. That isn't hurting me. Everyone that it need to be treated like 12015, at 1:50 p.m. the IN) said R96 kept telling that happened to her . R96 noking area, a fall and this no other staff received a the next day R96 reported a tright away, but did restigation regarding this	F 2	226			

MANE OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR SITRESTA DUBLISH, NIN 66602 OULD THE PROVIDER OF THE PROCESS OF THE PROCESS OF THE PROPERTY (EACH OSMOCKALE) OF THE PROCESS		MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIFEE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: AL BUILDING			(X3) DATE SURVEY COMPLETED			
PAYSHORE RESIDENCE & REHAB CTR CAN D			245227	e. WNG			11/	18/2015
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F226 Continued From page 18 had helped her remove a shirt, and a bit later offered help with cares which resident refused. Resident has multiple dx (diagnosis) and has been angry that she needs staff supervision for her smoking. There is no findings of abuse in this case." Under incident description "The resident reports that her hand is sore, and that an aide last evening hurt her hand during cares. Inhrestigation. An interview on 11/17/2015, at 11:25 a.m. with social services (SS)-B who said she hasn't been doing the vulnerable adult (VA) for 9 months to a year. She said it was transitioned to runsing at that time but in the last couple weeks was being transitioned back to the social services department again. S-S-B said she had nothing to do with Refe's VA report from July or the investigation of R96's broken finger. The DON said this is a she said fair. A final radiology report dated 7/1/15, indicated "There are likely degenerative in effology, however small avulsed fracture fragment is not completely excluded." A physician office visit dated 7/8/15, indicated "There is dark pumple ecolymosis present on the			B CTR		160	11 ST LOUIS AVENUE		
had helped her remove a shirt, and a bit later offered help with cares writch resident refused. Resident has multiple at ytilagnosis] and has been angry that she needs staff supervision for her smoking. There is no findings of abuse in this case." Under incident description "The resident reports that her hand is sore, and that an aide last evening hurt her hand during cares. Employee suspended pending investigation, and care can changed that 2 staff be in the room during cares. Investigation ongoing." There is no further investigation. An interview on 11/17/2015, at 11:25 e.m. with social services (SS)-B who said she hasn't been doing the vulnerable adult (VA) for 9 months to a year. She said it was transitioned to nursing at that time but in the last couple weeks was being transitioned back to the social services department again. SS-B said she had nothing to do with R96's VA report from July or the investigation. An interview with DON on 11/17/2015, at 3:01 p.m. said she did not have any further investigation of R96's broken finger. The DON said this is a she sald/she said and R96 has a lot of diagnosis' that make her unreflable. A final radiology report dated 7/1/15, indicated "There are likely degenerative in effology, however small avulsed fracture fragment is not completely excluded". A physician office visit dated 7/8/15, indicated "There is dark purple ecchymosis present on the	PRÉFIX	(EACH DEFICIENCY MUST 96 PRECEDED BY FULL			,	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
thenareminence, the volar wrist, and the dorsal thumb".	F 226	had helped her remove offered help with care Resident has multiple been angry that she in her smoking. There is case." Under incident description that her hand is sore, evening hurt her hand suspended pending in changed that 2 staff is investigation ongoing investigation. An interview on 11/17 social services (SS)-fidding the vulnerable syear. She said it was that time but in the last transitioned back to the department again. SS do with R96's VA reprinvestigation. An interview with DOI p.m. said she did not investigation of R96's said this is a she said of diagnosis' that male A final radiology report There are likely degand however small avulse completely excluded." A physician office visi "There is dark purple thenareminence, the	we a shirt, and a bit later is which resident refused. It (diagnosis) and has beeds staff supervision for in o findings of abuse in this pition "The resident reports and that an aide last it during cares. Employee investigation, and care can be in the room during cares." There is no further 1/2015, at 11:25 a.m. with 3 who said she hasn't been adult (VA) for 9 months to a transitioned to nursing at st couple weeks was being the social services in a said she had nothing to bort from July or the N on 11/17/2015, at 3:01 have any further in broken finger. The DON is he said and R96 has a lot to the her unreliable. It dated 7/1/15, indicated enerative in etiology, and fracture fragment is not it dated 7/8/15, indicated ecchymosis present on the	F	226			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245227	B. WING _		11/18/2015
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REQUEATORY OR LSC IDENTIFYING INFORMATION)			ID PROFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(XS) E (CMP)(GTION
F 241 SS≃D	not received. R96's care plan dated "Resident is a vulnera injury/abuse from othe Potential for retaliation Resident also noted to "[R96] has potential to abusive behaviors." Athls was to give R96 a possible. An interview with regist 11/17/15, at 11:13 a.m abuse to us regularly. correlation between R making reports of abut 483.15(a) DIGNITY AINDIVIDUALITY The facility must prominance and in an envenhances each reside full recognition of his control of the second on observation review, the facility fails residents (R49) was differented to the second of t	es were requested but were 11/10/13 indicated ble Aduit, at risk for ers due to cognitive deficits. In related to Bipolar Disorder. In glve money away." Also In demonstrate verbally An applicable intervention to the many choices as In said she (R96) reports RN-A said there is a In 96 not getting her way and In see an adjustion or In the seed in a disconnent that maintains or In the individuality. It is not met as evidenced In interview and document and to ensure that 1 of 1 In ressed in a dignified In the back, shoulder and It is ensuring that her	F 24	 Resident # 49 has had no negative outcomes from the alleged deficient practice. Social Services purchased additional items of clothing for R49, she has shown acceptance. Residents who do not have the ability make choices or do not have the ability communicate likes and dislikes or neghave the potential to be affected by the alleged deficient practice. Residents will be assessed which make the potential to be affected by the alleged deficient practice. Residents will be assessed which making che concerning clothing, grooming, name preferred to be called, and or appropried to be called, and or appropried in-serviced on areas that relate to digital transfer to the called to resident care with re- 	ity to ty to eds ie nay ices they iate will be nity, esident ieeds in n is will 12 nat l on r es full

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,,		CONSTRUCTION	(X3) DATS SURVEY COMPLETED	
		245227	B. WING			11/	18/2015
NAME OF PR	ROVIDER OR SUPPLIER		,	ST	REST ADDRESS, CITY, STATE, ZIP CODE		
BAYSHOR	RE RESIDENCE & REHA	AB CTR			01 ST LOUIS AVENUE		
			- iD	D	ULUTH, MN 55802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page		F	241			
	included failure to thr restlessness and agit annual Minlmum Data indicated R49 had se required extensive as transfers, dressing, e hygiene, and was freibladder and bowel. On 11/9/15, at 3:46 p the second floor dinir snapped up the back snapped and R49's incontinent product w. On 11/13/15, at 12:44 second floor dining redown the right side of that R49's entire right. When asked if R49 u off-shoulder, Nursing "Not usually". During her hot chocofate on floor. On 11/13/15, at 1:30 observation, R49 was wheelchair in front of station. R49 was no shirt or pants, but had that snapped down the leaving her knees an Because R49's lower	ation and diabetes. R49's a Set (MDS), dated 7/8/15, verely impaired cognition, sistance with bed mobility, ating, toileting and personal quently incontinent of			4 Observation rounds will be condutive (2) times per week for 12 weeks monitor that residents are dressed an groomed in a dignified manner. Any negative occurrence will be addresse immediately. The observation round documentation will be presented to the monthly QAPI committee for three to monitor the facility's system of has the resident's dressed and groomed in dignified manner. After three months QAPI committee will make a recommendation as to the need to contomite that the facility consistent practices that the resident's right to be dressed and groomed; that the facility promotes care for residents in a manimal maintains or enhances each resident' dignity and respect in full recognition their individuality. 5. The Administrator/designed will be responsible. Completed 12-18-2015.	d d d he months iving n a s the ntinue lly be y her that s n fo	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, 7	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B.WING_	B. WING		11/18/2015	
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL, TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		BE COMPLÉIXIN	
F 242	dated 10/09, directed maintain and protect reported to bodily privacy. 483.15(b) SELF-DETE MAKE CHOICES The resident has the reschedules, and health or her interests, assess care; interact with melboth inside and outsid choices about aspects facility that are significable to honor choices for 1 of 3 resident for choices. Findings include: On 11/9/15, at 2:49 p.m. R146 would like to be be daily prior to admission had given this information responded by tefling hir week. R146 was presented and responded in agriculture.	ed Quality of Life-Dignity staff shall promote, resident privacy, including staff shall promote, resident privacy, including staff shall promote, including staff shall promote, including staff to choose activities, a care consistent with his saments, and plans of imbers of the community let the facility; and make a of his or her life in the cant to the resident. Is not met as evidenced and document review, the frequency of bathing dents (R146) reviewed In family member (F)-B stated halted daily, and had bathed to the facility. F-B stated he on to staff, and the facility in R146 is bathed twice a not during the interview, and earnent. For didentified diagnoses that the and acute respiratory ata Set (MDS) dated in had severe cognitive	F2	A family care conference	s family we nd changed er, the resi ential to be ient praction m was ng a Reside emination:	ould d dont dent ce.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		2 45227	B. WING			11/18/2015		
NAME OF PROVIDER OR BAYSHORE RESIDE (X4) ID	NCE & REHA	LB CTR ATEMENT OF DEFICITINGIES	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 65802 ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PRÉFIX (EA	(EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PRESIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)			COMPLETION DATE	
(RN)-C si weekly bathed to the facilither preference, an previous On 11/18 (DON) was expect the bathing fill the residuation of the residuation o	ing. /15, at 9:48 tated the face ath day upon this a week, vice a week, vice a week, and asked rence for modern the facility hor requency. /15, at 12:00 as interview facility hor requency. /15, at 12:00 as interview facility hor requency. /15, at 12:00 as interview facility hor requency. /16, at 12:00 as interview facility hor requency. /17, at 12:00 as interview facility hor requency. /18, at 12:00 as interview facility hor requency. /19, at 12:00 as interview facility hor requency. /19, at 12:00 as interview facility hor requency. /19, at 12:00 as interview facility hor requency. /15, at 12:00 as interview facility hor requency. /15, at 12:00 as interview facility hor requency.	a.m. registered nurse fility assigned residents a madmission, and will provide RN-C stated R146 was however she was unsure if R146 or her family member fore then one or two baths a le if they asked about her fine. If p.m. the director of nursing and and stated she would hor resident choices for If procedure on Quality of Life Needs dated 10/09, directed final needs and preferences fied to the extent possible, lith and safety of the fidents would be (k)(2) RtGHT TO (NING CARE-REVISE CP) right, unless adjudged wise found to be the laws of the State, to g care and treatment or		242	 4. The resident's right for self-determination and choices will be disc with the resident and of guardian upon admission. And The Interdisciplinary will review each resident's right to sel determination and choices in their planeare at each quarterly care conference Initiated 12-1-2015. 5. An audit will be completed each me for the next three months to monitor the choices are offered and documented in Plan of care. Audits will be presented monthly QAPI committee for three me and then quarterly for the next year to monitor that a system assuring self-determination and resident choice is functioning. 6. The Director of Social Services / designce will be responsible with over by the Administrator. Completion date 12-31-2015. 1 Residents #152, who was on Hospite has documentation that weight loss is unavoidable; however resident does a meals in her room where staff offer chand encourage resident to cat. Reside has scheduled pain medication and documented as effective. 	reach Team If- If- In of In of In of In the It the		

	OF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245227	B. WING			11	11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 66802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X6) COMPLETION DATE	
F 280	disciplines as determined, to the extent practitude resident, the resident resident, the resident resident, the resident revised by a team each assessment. This REQUIREMENT by: Based on observation review, the facility fails care to include the modessessment for 1 of 1 from post tramatic head surgical intervention. In addition, deficiants 4 residents (R65) reviewed in addition, the facility fails of care for 1 of 1 in need of pressure ultimated in the residents (R61's care plan dated 1 "Potential for pain r/t [resident], compression dematitis in anal area and resident resident, compression dematitis in anal area.	wher appropriate staff in med by the resident's needs, edicable, the participation of ent's family or the resident's and periodically reviewed in of qualified persons after is not met as evidenced in, interview and document ed to revised the plan of ederate to severe pain (R61) reviewed for pain and acetabulum fracture, recommendations for 1 of ewed for dietary concerns colity did not update the residents (R152) reviewed cer prevention/treatment.	F 2	280				
	R61's admission recor	d indicated a diagnosis of		Ц				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:	1 ' '	A, BUILDING		COMPLETED	
		245227	B. WING	B. WING			18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		1	16	REST ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE ULUTH, MN 66802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC [DENTIFY:NG::NFORMA1::ON)	IC PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR'S DEFICIENCY)		(X5) COMPLETION DATE
F 280	admission Minimum I 10/29/15, indicated R impaired, had no beh in the past seven day had pain, and receive was at risk of falls, an more falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls without injutation of falls with fal	ession, hypertension, onary artery disease. R61's Data Set (MDS) dated 61 was severely cognitively avior problems, and felt sad s. The MDS identified R61 ad pain medication daily, and ad had a history of two or ary, and a fall with injury. Ited 9/8/15, 10/29/15 and red and R61 went from not be pain in the night to being from the pain. The pain was were on all. The assessment ad R61 only needing pain days, but the two dated f5 both indicated dally pain in needed.	F	280			

	OF DEPICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(XS) DATE SURVEY COMPLETED		
		245227	B. WING			11.	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1	STREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE PULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES FACH PERIODENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
	review the medication scheduled a pain medicalities request. We been here he doesn't his pain may be affect requested a regular pain order is for oxyco. The medical doctor all medications. RN-A als any behaviors. R152 dld not have a condeveloped to minimize and promote healing of According to the under admitted on 5/28/15, neuroendocrine carcinobstruction and significare Area Assessmen R152 had the "potentialicers. The care plan dated a identified a goal of has interventions identified protocols and policies documentation. There interventions in place potential for skin break A progress note dated had mepiplex on his coadmission for "prevential physician order dated (foam dressing) to the physician order directed Optifoam dressing (an	d the medical doctor will s. The medical doctor lication because of the realize since you have have good pain control and fing his relentlessness and ain medication. His new done 10 mg 3 times daily, so reviewed his other so said R61 does not have comprehensive care plan the the risk of development of pressure ulcers, ted face sheet, R152 was with metastatic froma, inferior vena cava cant nutritional deficits. A find dated 6/5/15, identified all to develop pressure s initiated on 6/5/15, lying Intact skin. The i included following facility and weekly treatment were no individualized to minimize the identified down. 5/28/15 revealed R152 becyx at the time of fative measures." A 6/17/15, identified mepiplex coccyx. On 6/19/15 a ad staff to place an absorbent all in one wound re barrier on the outside) to	F	280			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245227	B. WING_			11/18/2015
•	ROVIDER OR SUPFLIER RE RESIDENCE & REHA	BCTR		STREET ADDRESS, DITY, STATE, ZEP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DESIGIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORT (EACH CORRECTIVE ACTION S CROSS-REIFBRENGED YO'THE A DEFICIENCY)	SHOULD BE	DATE COMPLESION DATE
F 280	noted on the right but (cm) by 2 cm. A week completed 6/20/15, id but then identified "sk further assessment. F On 11/17/15, at 12:56 (RN)-A stated there we for R152. RN-A stated finalized for R152 yet. On 11/18/15 at 8:35 a (DON) stated she red she believed R152 "n DON stated she woul record and would pro On 11/18/15 at 10:00 copies of documentat "everything we have a review of the docume information provided, planning content. R158's significant characteristic contents and she was inset- up with a 5% dec The MDS included didementia. R158's care plan date R158 was at risk for resident in the resident of the resident characteristic contents.	e identified skin breakdown tock measuring 2 centimeter by skin assessment entified the skin was intact in broken at coccyx" with no k152 expired on 7/5/15. In m. Registered Nurse was no further care planning the care plan hadn't been the care plan hadn't been alled R152. The DON stated ever really opened up." The dhave to look at R152's vide additional information. I.m. the DON provided ion and stated it was on the wounds." Upon onts, there was no additional including no other care ange Minimum Data Set indicated R158 had inpairments. The MDS independent with eating after the in weight loss indicated. Agnoses of cancer and and 10/9/15, indicated nutrition secondary to fluid set and infection problems. It: iet as ordered record every meaf	F 2	80		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER	B CTR		STREEF ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 56802			
(X4) ID PREFIX YAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(XS) CX3MPLETION DATE
F 280	Continued From page	27	F:	280			
	an order for a regular lacked an order for a r R158's Weights and \ the following weights:	(lbs) -10% weight change weight change cord from 9/15/15, to following meal Intake		111111111111111111111111111111111111111			
	 55 meals at 51% - 7 27 meals at 76% - 1 The medical record lanutritional reassessmenthe care plan. 	00% cked evidence of a					
	On 11/17/15, at 8:03 a eating in the dining rook R158 was served hot of frozen brange juice During the observation coffee and and was seduring breakfast, R158 eat throughout the mejelly on her toast, staff brown sugar or ralsins	n R158 asked for more erved a total of 3 cups 3 was being encouraged to al and was assisted to put					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION LIDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245227	8. WING			11/	18/2015
BAYSHOR	ROVIDER OR SUPPLIER		ID	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802 ID PROVIDER'S PLAN OF CORRECTION			(X6)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD I			GOMPLETION DATE
F 280	member did not offer R158 ate 75% of hot toast, leaving the crus of coffee, 1/2 of her n R158 stated "I've had On 11/17/15, at 12:23 eating independently lunch meal. R158 wawith whipped topping 8 ounces (oz) of milk 100% of the oranges only bites of the taco R158 drank 100% of the observation R158 dining room ticket and her fork and not take the fork back down. From the dining room back to her room via When interviewed on registered dietician (Fibe weighed monthly and food Intakes are dietician. The RD furt decline in weight and would be reassessed further weight loss. The difficult case as she however stated R158 process. Upon review compared to the weighter RD stated R158 via the RD stated R158 via th	aff member to eat. The staff R158 anything else to eat. cereal, bites of eggs and her st. R158 consumed 3 cups tilk and no orange juice. The enough." It p.m. R158 was observed in the dining room for the served a cup of oranges, tace hotdish, mexican corn, and 8 oz of coffee R158 ate and whipped topping and hotdish and mexican corn. The milk and coffee. During the was busy playing with her downld frequently pick up a bite of food and then put length and propelled herself table and propelled herself table and propelled herself ther wheelchair. 11/18/15, at 9:05 a.m. the RD) stated residents are to at a minimum and weights reviewed monthly by the her stated if there is a food intake the resident for interventions to prevent the RD stated that R158 was a was on hospice care, its not actively in the dying of the RD's spreadsheet that in the medical record was not looked at for a of the RD inputting R158's	F	280	2. all residents have the potential to hat issues with care planning. 3IDT members and licensed staff with complete in-service on care planning including updates as needed for change status or condition, to be completed by 12/18/15. Care plans will be reviewed quarterly and discussed with resident family, and updated as needed; care plane reviewed updated as needed with a change in condition such as, but not exclusively, falls, skin issues, changes mentation or ADL status.; the Nurse Managers will recheck that care plans care sheets are updated with above chefully the provided with above cheful to the DON will be responsible and regulation will be provided to staff as needed. 5. The Director of Nursing /designee with provided to will be completed on or be 12-31-2015.	ill ge of y and or lans my and anges, cort ic cort icr eport inther	
	residents weight to or	ompare subsequent weights mission weight of 131.9 lbs					

Event ID: GYOR11

STATEMENT OF DEFIGIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING		11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUILL SCIDENTIFYING INFORMATION)	IÚ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 282	been reassessed for p 483,20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by c accordance with each care. This REQUIREMENT by: Based on interview at facility failed to follow plan to prevent pressuresidents (R22) review R22's quarterly Minim 9/25/15, indicated R22 Impairments and requivith bed mobility and I transfers. The MDS in diabetes mellitus, hem palsy. The MDS indicapressure ulcer (partial presenting as a shallo pink wound bed, without unhealed and was not previous assessment. R22's care plan dated resident had a pressur ischium (forms the low hip bone), Intervention administer medication.	Distated that she had her review and should have cossible interventions. ICES BY QUALIFIED E PLAN If or arranged by the facility qualified persons in resident's written plan of the intervention on the care are ulcers for 1 of 4 and severe cognitive intervention on the care are ulcers. It is a severe cognitive in the cluded diagnoses of a sistence with cluded diagnoses of a sistence are ulcers loss of dermis and cerebral atted R22 had a stage 2 thickness loss of dermis are open ulcer with a reduct slough), that was a present at the time of the sincluded; in a sordered and monitor in the sa ordered and monitor in the same and the	F 282	1 .Resident # 22 is followed by the WC	and Cusing c skin sident Tisk skin ed to on the ea and PI e a nue ons	

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		1, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 262	predicating pressure tolerance [assessmen schedule] quarterly at a monitor nutritional significant reposition. PRN in wheelchair arthistory of refusing. Frequires an alternational record comprehensive skin reduced to more quarterly and PR22's medical record comprehensive skin reduced from the care plan. The medical record consistent weekly sking the care plan. The medical record consistent weekly sking from the care plan. The medical record consistent weekly sking fr	the MD It, Braden [assessment for ulcer risk] and tissue int for repositioning and as needed (PRN) tatus, serve diet as ordered twice daily and PRN to skin, bony prominences of from staff for ing every two hours and and bed, resident has a ang air mattress on his bed chair. Lacked evidence of a risk assessment, to be RN per the care plan. acked a Tissue Tolerance are quarterly and PRN per dical record lacked any or tissue profusion. Lacked evidence of an assessments since lowing skin assessments are dated 7/1/15, 8/19/15, 15. recorded indicated the stage discovered on 9/2/15, and ters (cm) x 0.5 cm x a depth Vound base was 90% red and was moist in the, no odor. Surrounding blanched. Writer applied and will seek physician a place include alternating	F	282		

Facility 3D. 00688

PRINTED: 12/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (XI) PROVIDENSUPPLIER/CLIA MODE OF CORRECTION (XI) PROVIDENSUPPLIER/CLIA (XI) PROVIDENSUPPLIER/CLIA (XI) PROVIDENSUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION A, BUILDING			(XS) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & RE	EHAB CTR		15	REET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 65802		
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC (DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DERCIENCY)			(X5) COMPLETION DATE
F 282		on 11/17/15, at 2:19 a.m.	Fá	82			
	a quarterly Braden in observation on residence as never seen that type in the facility. RN-B	N)-B stated that the nurses do Scale and weekly skin dents, but they do not use a seesment and added she has e of assessment since starting verified that the weekly skin not completed weekly as eare	-				
	stated the facility do	on 11/17/15, at 2:38 p.m. BN-H bes not use a Tissue Tolerance essing for appropriate itloning schedules.					
F 2 8 5 88-0	director of nursing (are on a every 2 hor and that the nurses determine an appro- for residents. The D was repositioned tin plan. The DON state specific tool to asse DON further stated should be complete	on 11/18/15, at 10:20 a.m. the DON) stated that all residents urs repositioning schedule utilize the Braden Scale to priate repositioning schedule DON further stated that B22 nely according to his care ed the facility does not use a ass for tissue profusion. The that weekly skin observations d and documented.	FŞ	65			
	pre-admission scree program under Med	linate assessments with the ening and resident review licaid in part 483, subpart C to it practicable to avoid and effort.					
		rst not admit, on or after ly new residents with:					

FORM CMS-2567(02-98) Previous Varsions Obsolete

Event ID: GYQH11

Event ID: GYCHII Facility ID: 00589 If continuation sheet Page 32 of 116

Administration

12.31.20(5)

	OF DEFICIENCIES OF CORRECTION	(X:) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	1 7 .	RECONSTRUCTION		E SURVEY APLETED
		245227	B. WING		11/	18/2015
	(EACH DEFICIENC)	EHABIOTR TEMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		PREFIX (LACI) GORRECTIVE ACTION SHOUL		(XG) COMPLETION DATE
F 286	(i) Mental illness a (ii) of this section, unauthority has deternindependent physic performed by a pen State mental health (A) That, because condition of the indition of this section of this section of the indition of the individual is appointed in the individual is illness defined at \$4 (ii) An individual is retarded if the individual is retarded in \$483.102 related condition as This REQUIREMEN by: Based on Interview	s defined in paragraph (m)(2) nless the State mental health nined, based on an all and mental evaluation son or entity other than the authority, prior to admission; of the physical and mental vidual, the individual requires provided by a nursing facility; all requires such level of the individual requires for mental retardation. In a defined in paragraph tion, unless the State mental opmental disability authority or to admission— of the physical and mental vidual, the individual requires provided by a nursing facility; all requires such level of the individual requires of the physical and mental vidual, the individual requires are individual requires as for mental relardation.	F 285	1. The facility did re Level II PASSR for #146 and no outs resources/interve were required for resident. 2. Four residents we identified in the frequiring a Level None of the resident required outside resources/interversidents required for residents requiring programming new Director of Social The Director of Social The Director of Social The Director of Social The Level II residents in the Level II PAS requiring special programming.	r resident side entions r the ere facility II PASSR. dents entions. or reviewed r Level II ng eds with the I Services. ocial ude a f care for all identified	

	FOR DEPOTENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. SUILDING		(X3) DATE SURVEY COMPLETED	
		245227	Đ. WING	·	11/	18/2015
	PROVIDER OR SUPPLIER	EHAB ÇTR	1	THEET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	LEWENT OF DELICENCIES WINDLE BE SUCCESSED BA SOM WINDLE	DU PREFIX TAG	PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE) TO THE APPROP DEFICIENCY)	BE	(XX) COMPLETION PARK
F 285	and Resident Reviet 1 residents (R146) is developmental disal Elndings include: R146's Admission Fithat included Down'dated 8/17/15, lacke troatmont needs. R146's Level II PAS R146's Level II PAS R146 had a develop required convalesce 10/6/15. The Level II R146'required active treat specified in R146's would be met while facility. On 11/13/15, the fact a copy of R146's Level II PASRR, and received a copy of it SW-A verified the fact Level II PASRR preserved in R146's R146 participate in 10 n 11/18/15, at 9:4 county's responsibility received the Level II currently walting for county worker. SW-	II Preadmission Screening by (PASRR) evaluation for 1 of reviewed with a bility. Record identified diagnoses a syndrome. The care planed indication of active. RR dated 8/10/15, indicated organized disability, and ent care from 8/6/15, to 1 PASRR further identified a treatment, and the facility ment needs will have been individual service plan, and R146 resided in the nursing bility was requested to provide vel II PASRR, On 11/17/15, A provided a copy of R146's distance the facility had just from the county via fax. utility had not reviewed R146's	F 285	An audit of all residents and all admissions requiring a Level II screen and assed as needing speprogramming will be conducted every month to monitor that specialized plans of care have be developed for these residents. 4. the audits will be presented to monthly QAPI committee for the months. After three months the QAPI committee will make a recommendation as to the need continue to monitor that Level I residents have the PASSR and specialized care plan. Complettion date of 12-31-2015	ecial o the ree	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	E CONSTRUCTION	(XS) DATE SURVEY COMPLETED	
		245227	B. WING		117	18/2015
·	PROVIDER OR SUPPLIER PERESIDENCE & RE	EHAB CTR	1	STREET ADDRESS, CITY, STATE, ZIP COUL 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(Xd) ID PREFIX TAC	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DEMTREYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPED DEFICIENCY)	SE .	(X/I) COMPLETION DATE
F 285	she spends a lot of A policy and proced	time in her room. lure on Level II PASRR	F 285			
		quested, but not provided. CARE/SERVICES FOR EING	F309		LABOURDON A.	
	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain lest practicable physical, social well-being, in a comprehensive assessment	-			
	by: Based on observative review, the facility facility facility facility facility facility facilities assess pain and imprelleve moderate to (low back) and acet fractures for 1 of 1 pain. This deficient to R61. In addition, coordination of care hospice agency for reviewed for hospic provide services to aphysician for 1 of 1. Findings include: H61's admission rediagnoses including	cord identified multiple traumatic subdural				
	hematoma, lumbar	compression fracture and hip ission Minimum Data Set				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245227	B. WING_			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	10	18	TRRET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFIC:ENC	TTAMENT OF DEPICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DAZE COMPLETION DAZE
F 309	problems. The MDS in received pain medicar falls with a history of further identified R61 assistance of one stat (ADLs) and had not a days. Pain assessments we 10/29/15 and 11/10/15 night from the pain. The dated 11/10/15, identificated 11/10/15, identifications needed. The Care Area Asses 10/29/15, indicated ve moaning, groaning, arpain. The characteris of the pain was not codated 11/3/15, identificate plan directed pair monitor for and report appetite and verbal/no pain. The care plan dinon-pharmacological alleviate pain. The Medication Admir 9/15, 10/15, and 11/15 started receiving oxyconeeded (PRN) on 10/2 survey) when the med provide pain medicatic oxycodone was given	indicated R61 was inpaired and had no behavior dentified R61 had pain and then daily, and was at risk of alls with injury. The MDS required extensive if for activities of daily living imbulated the past seven in the pain was rated moderate most recent assessment fied daily pain and pain in the pain was rated moderate most recent assessment if it is in the pain was rated moderate most recent assessment if it is in the pain was rated moderate if it is in the pain and pain in the pain was rated moderate it is, frequency and intensity in pleted. R61's care plan and a potential for pain. The in medications as ordered, changes in routine or in-verbal complaints of it include any interventions to help its in the pain in the	F	809	Mon-Fri and the nurse managers review any resident changes or /is Any issues with follow through an addressed with staff immediately, education is provided as needed. 4.The DON reports any issues to t QAPI monthly. After three months QAPI committee will make a recommendation as to the need for reeducation or revisions to the process. Completion date of 12-31-2015.	he s the	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245227	B. WING		11/18/20	15
	ROWDER OR SUPPLIER RE RESIDENCE & REHA		15	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE ULUTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC [DENTIFYING INFORMATION]	ID PREIFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMI	(XB) FLETION IATE
F 309	An observation of R6 a.m. lying in his bed will pillow under them. What a 8/10 (a verbal parain and 10 was their An interview on 11/9/therapist (PT)-A ident R61 10/22/15, to 10/3 to current. She said withospital after his subchad orders for all threoccupational, speech PT-A stated they use (facial pictures) with FPT-A continued to stareferral they only saw attempted to ambulate ambulate. He could obed to chair with a weal to of pain cause of The next request for fill/3/15, after returning fracture from another weight bearing as disciplines evaluated (transcutaneous efect his pain. R61 rated his pain. R61 rated his pain. R61 rated his pain. An interview on 11/12 therapy assistant (PT pain using the Wongrated his pain a 10/10 the sain and the pain and the pain and the sain and the sain and the sain and the wongrated his pain a 10/10 the sain and the wongrated his pain	doses which could have 1 on 11/12/2015, at 10:38 with his knees up and a fren asked he rated his paln in scale where 1 was no most pain he has ever had). 15 at 1:00 p.m. with physical ified they had started seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his seeing itified they had started his s	F 309			

Facility ID: 00589

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TYPLE CONSTRUCTION ING			(X3) DATE SURVEY COMPLETED	
		245227	B, WING_			111	/18/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1601 ST LOUIS AVENUE DULUTH, MN 55802	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST 82 PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 309	11/9/15. She slated the too short for R61. She grest had not been R61's leg on a stool a PTA-A told PT-D that leg rest as the leg rest as the leg rest short for him. R61 months whole time PTA-A was repeatedly said "it hur At 8:54 a.m. PTA-A as was and he said 10/10 continue the therapy oballoon to play ball. A subsequent intervie PTA-A said R61 has releg due to pain. PTA-bearing as tolerated believel. She said she us after an injury but has "extreme pain." She segave him something for important to have schelling as tolerated because of his back a pillow between R61's wouldn't straighten his say R61's wheelchair hurt him. A 10:38 a.m. while R61 the rest wouldn't straighten him.	at 8:13 a.m PTA-A ed R61's wheelchair on he leg of the wheelchair was e could not explain why the adjusted for R61. PTA-A put his leg kept falling off the t on the wheelchair was too baned and whimpered the s moving his leg. R61 ts" and "ouch, ouch, ouch." sked R61 what his pain level D. PTA-A was not able to on his legs so she used a w on 11/12/15, at 9:02 a.m. hot been able to move his A stated he was weight but can't walk due to his pain housily walks people sooner hot walked him due to be added pain medications. at 10:11 a.m. nursing d R61 cried out in pain a lot hid hip injury. He said the legs in bed was because he seleg out. She went on to did not fit him and the han interview on 11/12/15, at was lying in bed, this writer pain and he rated his pain		309				

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	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA ///DENT/F/CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(XS) DATE SURVEY COMPLETED	
		245227	8. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	REET ADDRESS, CITY, STATE, ZIP CODE 641 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y WUST BE PRECEDED BY FULL LSCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) (COMPLETION CATE
F 309	rated his pain as 10/1 is still able to move at with therapy. PT-A siboard to the Nu Step PT-A sald there were interventions used for didn't know why the TPT-A said when physevaluation on 11/6/15 said they changed his didn't fit him well. PT-leg didn't f	y are in pain. She said R61 0. PT-A said if the resident of transfer they go ahead aid he used the sliding but R61 grimaced in pain. In one pharmacelogical of R61's pain today. She rendered it pain today. She rendered it pain today. She rendered it pain today is wheelchair because it is wheelchair because it is wheelchair because it is wheelchair because it is wheelchair because it is wheelchair because it is and his leg kept sliding off mair. She said they put a calfining after the discussion 8/15, at 8:47 a.m. (OT)-K asked R61 to rate it at a 6/10 located near his she would tell the nurse. 15, at 2:28 p.m. that she are hall but "I know he is alling in pain." 8/15, at 2:29 p.m. trained (TMA)-K said she used a hall but "I know what others in levels. The order was for ligram) 1 - 2 tablets every 3 she said if R61 had a pain ave 1 tablet. If he had a pain		809			

Facility ID: 00589

	ATEMEN' OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245227	8. WING			11/18/2015			
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		•		ORESS, CITY, STATE, ZIP CODE UIS AVENUE VIN 65802	<u>,</u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	312	(X6) COMPLETION DATE		
F 309	pain control. She said in pain. RN-A stated a same pain scale and do not us any non pha Interventions and "we since survey started F control. She further staffecting his restlessor regular pain medication oxycodone 10 mg 3 till A progress note dated identified R61 was residentified R61 had hot PT-M stated therapy to scale. R61 rated his patherapy and did not aptherapy and did not appear to the last time pain, he said it was mot aware of any stanfacility, for pain managements.	ed he did not have adequate she has seen him grimace all staff should be using the they are not. She said they armacological pain should." RN-A stated R61 doesn't have good paln ated R61's pain may be ess so staff requested a con. His new pain order is for mes dally. If 10/24/15, at 1:11 a.m. stless and climbing out of men asked if he had pain I R61 said yes. If 7/15, at 9:05 a.m. PT-M cocks the nerve synapse. State of a Wong Baker pain pain as "a lot" on the Baker estarted physical therapy ing with his left leg, R61 ide hurt. PT-M did not ask a in medication before coply the TENS unit. If 5, at 7:55 a.m. RN-H a pain scale. She just asked in was mild, moderate or she asked R61 about his oderate. She sald she was dardized method in the gement assessments.	F	809					

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NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE, 2IP CODE 10 SAME OF PROVIDER OR SUPPLIER SAME OF PROVIDER OR SUPPLIER SAME OF PROVIDER OR SUPPLIER SAME OF PROVIDER OR SUPPLIER SAME OF PROVIDER OR SUPPLIER SAME OF SAME OF SUPPLIER SAME OF SUPPLIER SAME OF SAME OF SUPPLIER SAME OF SAME OF SUPPLIER SAME OF SAME OF SAME OF SUPPLIER SAME OF		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS NO PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COME	SURVEY PLETED		
PASTHORE RESIDENCE & REHAB CTR PAGE DECIDENCE SUMMARY STATEMENT OF DEFICIENCIES EACH DECIDENCY MUST BE PRECEDED BY FULL PREFIX PREFIX PROVIDENCE PLAN OF CORRECTION BE CARD-CONTROLL BE PREFIX PROVIDENCE PLAN OF CORRECTION BE CARD-CONTROLL BE CAR			245227	B. WING			11/18/2015	
PAYSHORE RESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & REHAB CTR PAYSHORE PRESIDENCE & PAYSHORE PROPRATE	NAME OF PE	ROVIDER OR SUPPLIER						
FREFIX TAB REQULATORY OR LSt: IDENTIFYING INFORMATION) F 309 Continued From page 40 non-pharmocological interventions for pain on 11/17/15. "We saw that as a need for him." A facility polity titled: PAIN ASSESSMENT PROTOCOL reviewed 11/02, indicated, "It is the policy of Bayshore to provide for the optimum quality of life for every resident. Quality of Life includes individualized management of pain. Management of pain includes accurate assessment, pharmacological and non-pharmacological methods, and physical and psychosocial interventions." R 109 received hospice services, and the facility failed to provide coordination of care. Findings include: R 109's Admission Record identified diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 91/41/5, indicated R 109 had severe cognitive impairment, and required extensive to total assistance of staff with bed mobility, transfers, dressing, eating, mobility, personal hygiene, bathing and toleting. R 109 began receiving hospice services on 12/27/15, for end of life services due to the diagnosis of Alzheimer's disease. The most recent certification by the hospice agency was 9/17/15, and at that then it was determined he would receive skilled nursing services once a week for nine weeks, and nursing assistant (NA) services twice a week for nine weeks. On 11/12/15, at 1:27 p.m. nursing sessistant	BAYSHOR	RE RESIDENCE & REHA	B CTR					
non-pharmocological interventions for pain on 11/17/16. "We saw that as a need for him." A facility policy tilled: PAIN ASSESSMENT PROTOCOL reviewed 11/02, indicated. "It is the policy of Bayshore to provide for the optimum quality of life for every resident. Quality of Life includes Individualized management of pain. Management of pain includes accurate assessment, pharmacological and non-pharmacological methods, and physical and psychosocial interventions." R109 received hospice services, and the facility failed to provide coordination of care. Findings include: R109's Admission Record identified diagnoses that included Atzheimer's disease. The quarterly Minimum Data Set (MIOS) dated 9/14/15, indicated R109 had severe cognitive impairment, and required extensive to total assistance of staff with bed mobility, transfers, dressing, eating, mobility, personal hygiene, bathing and tolleting. R109 began receiving hospice services on 12/2/15, for end of fife services due to the diagnosis of Alzheimer's disease. The most recent certification by the hospice agency was 9/17/16, and at that time it was determined he would receive skilled nursing services once a week for nine weeks, and nursing assistant (NA) services twice a week for nine weeks, and nursing assistant	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
(NA)-K was interviewed, and stated the hospice NA came to the facility two or three times a week. NA-K stated they came at different times of the week, and different times of the day. NA-K stated	F 309	non-pharmocological 11/17/15. "We saw the A facility policy titled: PROTOCOL reviewed policy of Bayshore to quality of life for every includes Individualized Management of pain it assessment, pharmacon-pharmacological psychosocial interven R109 received hospid failed to provide coordinated to provide coordinated R109's Admission Rethat Included Alzheim Minimum Data Set (Mindicated R109 had stand required extensive with bed mobility, transmobility, personal byg R109 began receiving 12/2/15, for end of life diagnosis of Alzheime recent certification by 9/17/15, and at that till would receive skilled the week for nine weeks, services twice a week On 11/12/15, at 1:27 (NA)-K was interviewed NA came to the facility NA-K stated they came	interventions for pain on at as a need for him." PAIN ASSESMENT of 11/02, indicated. "It is the provide for the optimum of resident. Quality of Life of management of pain. Includes accurate cological and methods, and physical and tions." The services, and the facility dination of care. Cord identified diagnoses er's disease. The quarterly IDS) dated 9/14/15, evere cognitive impairment, at to total assistance of staff insfers, dressing, eating, giene, bathing and toileting. If hospice services on a services due to the pr's disease. The most the hospice agency was me it was determined he nursing services once a and nursing assistant (NA), for nine weeks. P. m. nursing assistant ed, and stated the hospice y two or three times a week, the at different times of the	F	309			

-Facility ID: 00589

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED		
		245227	B. WING			1 1	1/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	,	•	1601	EET ADDRESS, CITY, STATE, ZIP CODE I ST LOUIS AVENUE LUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	'A'TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFY)NG (NFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	was going to be at the On 11/17/15, at 9:36 (RN)-C was interview NA schedule was "sp RN-G stated the facility prior to coming the hospice NA-s schedule hospice NA's have the facility does not keep the facility does not keep the facility was aware schedule. The facility policy and Program dated 2/14, participates i the hospican of care between and resident/family was aware schedule. R143 did not receive assessments of clinic corresponding physical According to his admitted on 7/13/15, plan for rehabilitation diagnosis report date diagnoses including rambulation (RBKA), of Admission orders for full code status; accutimes a day, call if resmilligrams/deciliter metalligrams/deciliter are of when the hospice NA e facility to care for R109. a.m. registered nurse red, and stated the hospice oradic" and "they just come." ity does not have the le, and they do not call the g out. RN-G further stated e their own schedule, and now when they are coming. 7 a.m. the director of nursing ed and stated she assumed e of the hospice NA visit I procedure on Hospice directed when a resident sice program, a coordinated the facility, hospice agency ill be developed. timely and accurate al changes with ian updates as needed, ission face sheet, R143 was with a short term admission services. The resident of 7/13/15, Identified multiple light below the knee tiabetes and hypertension. R143 on 7/13/15, included check (blood sugar) four	F	309				

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		245227	27 B. WING			11/18/201		
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1601	EET ADDRESS, CITY, STATE, ZIP CODE ST LOUIS AVENUE JUTH, MN 55802			
(X4) ID PREFIX TAG	1 '		IC PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X6) COMPLETION DATE
F 309	medications. R143's a pounds. R143's admit dated 7/20/15, identification assistance with calconfused. In addition, have a shortened life. On 7/14/15 at 12:22 p. Administration Record sugar (BS) of 297 mg 229 pounds. There with hyperglycemia (high Enot updated as ordere medications to assist management. No weight was obtain 7/16-17/15 R143 weight was no weight obtainer R143 weighed 231 powas obtained. On 7/21/18 a fax was physician identifying "tabs. There was no further was no f	week - call MD; and multiple admission weight was 233 ssion Minimum Data Set ed he needed extensive to ares and was moderately it identified R143 did not expectancy. a.m. the Medication of (MAR) identified a blood /dL R143's daily weight was as no assessment for as no assessment for ed. R143 was on no with blood sugar ed on 7/15/15. On cycle 230 pounds. There ed on 7/18/15. On 7/19/15 pounds. On 7/20/15 no weight sent to the primary many abnormal values for other assessment.	F	903				

Facility ID: 00599

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION		E SURVŒY IPLETED
		246227	9. WING			1 11	/18/2015
NAME OF D	ROVIDER OR SUPPLIER	Z-TOZET	1	e.	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,,	71012010
14111112 01 11	to the city and the city						
BAYSHOR	RE RESIDENCE & REHA	B CTR			SO1 ST LOUIS AVENUE IDLUTH, MN 55802		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	la la		PROVIDER'S PLAN OF CORRECTION		(X6)
PREFIX TAG	·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS REPERSACED TO THE APPROPRIA DEFICIENCY)		DATE DATE
		1071					
F 309	Continued From page	43	l F3	309			
	. –	e daily weight had not been					
	obtained and there wa						
		dentified problem. At 2:00	i				
	-	of 260 mg/dL. The physician	1				
		there was no assessment	1				
		ere was no daily weight on	1				ll f
]	7/23/15. In addition or		1				
	R143's blood pressure		ļ				
		d blood pressures had	-				
		5/80. No other assessment					
	was completed and th						
	updated.						
	Another fax was sent I	to the physician on 7/24/15					l i
	identifying on 7/19/15	R143's weight was 231.5					
[pounds and today was	s 242.3 pounds. It further					
	identified R143 had a	notable increase in edema					
	of legs, scrotum, hand	ls/arms. There was no					
	further assessment ob	stained or provided. On					
	7/24/15 the physician	ordered labs and					
	medication changes a	nd requested the facility fax		1			
		occult and orthostatic	!				
		ldition the physician ordered					
	a chest x-ray (CXR), a						
	(ECG). Although the o						!
- 1	-	transcribed until 7/25/15.					
		vork was no collected until					
- 1		RN-A on 11/17/15 at 1:10					
	p.m. revealed she did		l				
	transcription and imple						
	physician orders had t						
		entified "possible coronary					<u> </u>
		no evidence the physician					j
1		R dated 7/25/15 identified					
		pattern" which was faxed to					
		15. There was no dally				i	
		15. On 7/26/15 the occult					[
	stools came back posi						[
		to the physician. Although it					
	was stamped "Faxed"	the area for		I			

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEPICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245227	B. WING_		11/18/2015		
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEIPED BY FULL SCIDENTIFY:NG INFORMATION)	FD PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD : CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(XG) . GOMPLETION DATE		
F 309	indicated there was no physician had been no results. On 7/26/15 Repounds for a total gala admission on 7/13/15 were completed and nower provided. On 7/29/15 at 2:00 at a caregiver answered back hurt wanted to be the caregiver was talk became cyanotic and was called and cardic was provided until padetermined to be explicated there had be R143's condition. RN not updated with the lowas being monitored stated the facility had hyper/hypoglycemia experience initiated here. Recalled the physician weights but "just not experience also stated it was that there was nothing further orders had the RN-A stated she remaware of "some of the was updated on all of that as she reviewed "gone forward and up	blank. Interview with I)-A on 11/15 at 1:10 p.m. Io indication in the record the otified of the occult stool 143's weight was 258.5 in of pounds 25 since. No further assessments no further physician updates in the call light. He stated his e turned on his side. While sing to the resident he unresponsive. A code blue apulmonary resuscitation ramedics arrived. R143 was ired at 3:05 a.m. In 11/17/15 at 1:10 p.m. seen no assessments of A stated the physician was blood sugars and nothing for those changes. RN-A begun monitoring for every shift but that had not N-A further stated she being updated on some every day." RN-A stated she e we notified him." However, "unusual and suspicious"	F3	1. No residents were affected by the deficient practice of failing to coord; care with Hospice. 2. All Hospice residents may be affer the alleged deficient practice. 3. An interdisciplinary meeting was with Hospice on 12-9-2015 regarding coordination of care. Meetings are scheduled every two weeks. Hospice providing schedules of the nursing a visits every Monday.	nate eted by neld is		

Facility ID; 00589

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(XS) DATE COMP	SURVEY PLETED
		245227	B. WING_			11/	18/2015
			Io PREFIX	16 D	TREST ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		cross-referenced to the appropriate deficiency) 4. Minutes of the biweekly meeting w.		DATE
	emergency room had from the physician. Interview with the resi 11/17/15 at 2:45 p.m. R143 on 7/24/15. He I weight gain and he su abdominal cavity) and indicated R143 had m the facility had not red the time of this reside the results received fr 7/24/15, "things looke R143 had the fluid over pancytopenia (deficient components of the bload platelets). P-A we R143 had bone marror required very aggress the Issues were follow treatment. When interviewed on director of nursing (DC a quality review procedeath records. The DC reviewed a death recondifications but "since been a question of wright for the procedeath records and the procede in the proc	dents physician (P)-A on indicated he had seen had been updated in R143's espected ascites (fluid in the fluid overload, P-A further ultiple co-morbidities and seived a lot of information at int's admission. Based on om the tests ordered on diterible," going on to say erload, ascites, and ney of all three cellular and red cells, white cells, and on to say he believed wissues that would have live tests to determine what red by very aggressive 11/18/15 at 11:36 a.m. the DN) stated when she ard she reviewed for a live been here there hasn't congful death." The DON majority of dea(hs were and no physician had ever death records weren't stated R143 was refusing ult to get him to cooperate.	F3	609	4. Minutes of the biweekly meeting will hospice will be reviewed at the month QAPI committee to assure coordinatio care is continuing. 5. The Director of Nursing/designee is responsible. I Resident # 143 expired 7-29-2015. 2. All residents have the potential to be affected by the alleged deficient praction of the providing services as directed by a physician. 4. The facility will audit two (2) reside charts per week times twelve weeks to monitor license staff are providing service as directed by a physician. Any negative courrence will be immediately report the Director of Nursing. These audits will make a recommendation as to the to continue to monitor that the license are providing services as directed by the Physician. 5. The Director of Nursing /designee will be incompleted by the physician. 5. The Director of Nursing /designee will physician date of 12-31-2015	of n of ce, ce, ce, co will three ins, ce need staff ie	
t t	PREVENT/HEAL PRE		F 3	14			
	Based on the compret	nensive assessment of a					

NAME OF PROMOBER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE 2IP CODE 1697 ST LOUIS AVENUE DULUTH, MN 55802 DULUTH, MN 55802		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIF/CATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
### PAYSHORE RESIDENCE & REHAB CTR PAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802			245227	B. WING				11/	18/2015
F 314 Continued From page 48 resident, the facility must ensure that a resident who enters the facility must ensure that a resident who enters the facility must ensure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services to prevent and promote healing of pressure ulcers for 2 of 4 residents (R22 and R152) reviewed for pressure ulcers. Findings Include: R22's quarterly Minimum Data Set (MDS) dated 9725/15, indicated R22 had severe cognitive impairments and required extensive assistance with transfers. The MDS included diagnoses of diabetes mellitus, hemiparesis and cerebral palsy. The MDS indicated R22 had a stage 2 pressure ulcer (Partial thickness loss of demise presenting as a shallow open ulcer with a red pink wound bed, without slough), that was unhealed and was not present at the time of the previous assessment. The skin Care Area Assessment (CAA) dated	BAYSHOR (X4) ID	RE RESIDENCE & REHA	B CTR ATEMENT OF DEFICIENCIES		1601 ST LOUIS AVENUE DULUTH, MN 55802 ID PROVIDER'S PLAN OF CORRECTION				
F 314 Continued From page 48 resident, the facility mithout pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services to prevent and promote healing of pressure ulcers for 2 of 4 residents (R22 and R152) reviewed for pressure ulcers. Findings Include: R22's quarterly Minimum Data Set (MDS) dated 9725/15, indicated R22 had severe cognitive impairments and required extensive assistance with transfers. The MDS indicated R22 had a stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), that was unhealed and was not present at the time of the previous assessment. The skin Care Area Assessment (CAA) dated					`	CROSS-REFERENCED TO THE APP			
developing pressure ulcers due to impaired program. mobility, incontinence, needed extensive 5. The Director of assistance with positioning and had a history of healed pressure ulcers. Nursing/designee with	F 314	resident, the facility method enters the facility does not develop presindividual's clinical conthey were unavoidable pressure sores received services to promote he prevent new sores from this REQUIREMENT by: Based on observation review the facility failed services to prevent and pressure ulicers for 2 of R152) reviewed for pressure ulicers for 2 of R152) reviewed for pressure ulicers for 2 of R152) reviewed for pressure ulicers for 2 of R152) reviewed for pressure ulicers for 2 of R152) reviewed for pressure ulicers for 2 of R152) reviewed for pressure ulicers for 2 of R152). The MDS indicated R21 impairments and requivith bed mobility and transfers. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy. The MDS indicates mellitus, hen palsy, incontinence assistance with position more assistance with position menters and resident mellitus.	sust ensure that a resident without pressure sores sores unless the addition demonstrates that a resident having es necessary treatment and ealing, prevent infection and mideveloping. is not met as evidenced in interview and document ad to provide care and ad promote healing of of 4 residents (R22 and essure ulcers. In Data Set (MDS) dated a stage 2 total assistance with included diagnoses of interview and cerebral ated R22 had a stage 2 thickness loss of dermis ow open ulcer with a red out slough), that was a time present at the time of the sessesment (CAA) dated the R22 was at risk for alicers due to impaired, needed extensive and particular and had a history of	F	314	WCC nurse, the would decreased in size, an free of signs and syminfection. Resident his of refusing reposition results in occasional Staff continue to encrepositioning. 2. All residents would be considered at risk for deficient practice. 3. The Nursing staff we reeducated on skin with focus on prevention development of would be considered at risk for deficient practice. 4. Nurse nurses are plus laminated card underesidents with instruing return to nurse and lange on the Unit to repositioning. 4. Nurse managers will logs and report to the QAPI committee. Aft months the QAPI committee as to the need to commonitor the reposition program. 5. The Director of	nd hand remark his his his his his courage of alleger his his his his his his his his his his	a sto	

ANAME OF PROVUDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR SUBMANY STATUS OF THE PROPERTY OF DEPT STATE OF DEPT STATE OF DODE 1649 ST. LOUIS AVENUE DULLTH, MN \$5802 FOR SUBMANY STATUSHY OF DEPT STATE OF DEP STATE OF DEPT STATE OF DEP STATE OF DEPT STATE OF DEP STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEPT STATE OF DEP STATE OF DEP STATE OF DEPT STATE OF DEP STATE OF DEP STATE OF DEP STATE O		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1		CONSTRUCTION		E SURVEY PLETED
In MARE OF PHONDER' OR SUPPLIENT BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55022 DULUTH, MN 55022 FREETY TAGE SEQUENTIFYING INFORMATION) FREETY TAGE SEQUENTIFY IN STREET OF CORPORATION INFORMATION INFORMAT			245227	B. WING_			11	/18/2015
FREFIX TAG REGULATORY OR ISC DIGHTEVING INFORMATION) F 314 Continued From page 47 R22's care plan dated 8/22/15, indicated the resident had a pressure ulcer to the right ischium (forms the lower and back part of the hip bone), interventions included: - administer medications as ordered - administer medications as ordered and monitor for effectiveness weekly skin assessment, Braden [assessment for predicating pressure ulcer risk] and fissue tolerance [assessment for repositioning schedule] quarterly and as needed (PFN)] - monitor nutritional status, serve diet as ordered - moisturizer applied twice daily and PRN to skin, do not massage over bony prominences - weight bearing assist from staff for significant repositioning every two hours and PRN in wheelchair and bed, resident has a history of refusing, - requires an alternating air mattress on his bed and cushion in wheelchair. R22's medical record lacked evidence of a comprehensive skin risk assessment, to be done quarterly and PRN por the care plan. R22's medical record lacked a Tissue Tolerance Assessment, to be done quarterly and PRN por the care plan. R22's medical record lacked any assessment related to tissue profusion. R22's medical record lacked evidence of consistent weekly skin assessments since June of				,	16	601 ST LOUIS AVENUE		
F 314 R22's care plan dated 9/22/15, indicated the resident had a pressure ulcer to the right ischium (forms the lower and back part of the hip bone), interventions included: - administer realications as ordered - administer treatments as ordered and monitor for effectivenese weekly skin assessment, Braden [assessment for predicating pressure ulcer risk] and itsue tolerance [assessment for a needed [PRN] - monitor nutritional status, serve diet as ordered - moisturizer applied twice daily and PRN to skin, do not massage over bony prominences - weight bearing assist from staff for significant repositioning every two hours and PRN in wheelchair and bed, resident has a flistory of refusing - requires an alternating air mattress on his bed and oushion in wheelchair. R22's medical record lacked evidence of a comprehensive skin risk assessment, to be done quarterly and PRN per the care plan. R22's medical record lacked a 7:22/15, indicated R22 was at a low risk for developing pressure ulcers. R22's medical record lacked and PRN per the care plan. R22's medical record lacked any assessment, to be done quarterly and PRN per the care plan. The medical record lacked any assessments related to tissue profusion. R22's medical record lacked evidence of consistent weekly skin assessments since June of	PREFIX	(EACH DEFICIENC)	A WINSJ, BE SWECEDED BA LITT	EDEO 8Y FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
LINUTE LINE TOLICULUITA EVID DECARRIGADES SITAS	F 314	R22's care plan dated resident had a pressur ischium (forms the low hip bone), intervention - administer medicatic - administer treatment for effectiveness. - weekly skin assessmen changes reported to tit - skin risk assessmen predicating pressure utolerance [assessmen schedule] quarterly ar - monitor nutritional stirmoisturizer applied to do not massage over - weight bearing assis significant repositionin PRN in wheelchair and bistory of refusing. - requires an alternational comprehensive skin rid done quarterly and PR R22's medical record comprehensive skin rid done quarterly and PR R22's medical record for R2	I 9/22/15, indicated the pre ulcer to the right wer and back part of the pre included: ons as ordered and monitor ment by a nurse, with the MD to the present for ulcer risk] and tissue at for repositioning and as needed [PRN] tatus, serve diet as ordered who prominences at from staff for any prominences at from staff for any every two hours and died, resident has a lacked evidence of a lacked evidence of a lacked evidence of a lacked evidence of a lacked a Tissue Tolerance e quarterly and PRN per lical record lacked any itssue profusion.	F3	314	be responsible. Completion date of		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/18/2015	
	ROVIDER DR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS, CITY, STATE, ZIP CO 1601 ST LOUIS AVENUE DULUTH, MN 55802)DE		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	NISHOULD BE EAPPROPRATE	(X5) COMPLETION DATE	
F 314	stage 2 pressure ulce and measured 4.5 ce depth of less than 0.1 90% red with 10% ye appearance. No exud tissue intact, pink and foam border dressing orders. Interventions pressure mattress an Skin/Wound Noted ch 11/10/15 with require. The medical record lare-assessment of the ulcer interventions or the current pressure ut A fax was sent to the regarding the current dressing not staying i responded and order dressing to be change. Review of the medical that the wound or drewere observed daily. When interviewed on nursing assistant (NA be repositioned every assistance to repositional alternating air pressure.)	atted 7/1/15, 8/19/15, 15. If recorded indicated the ar was discovered on 9/2/15, ntimeters (cm) x 0.5 cm x a cm. "Wound base was llow tissue and was moist in ate, no odor. Surrounding I blanched. Writer applied and will seek physician in place include alternating discovered wheel chair cushion." Interest weekly from 9/22/15-discovered wound desciptions. Incked any evidence of a residents current pressure an analysis to the cause of ulcer. Inchest of a foam in place. The physician ed a thin hydrocolloid ed every 3 days. If record lacked evidence ssing with surrounding skin 11/17/15, at 7:14 a.m. 1-10-15 stated that R22 was to	F :	314			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245227	B. WING.			11	/18/2015
NAME OF PI	ROYJOER OR SUPPLIER	270221			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
					1601 ST LOUIS AVENUE		
BAYSHOR	RE RESIDENCE & REHA	B CTR			DULUTH, MN 55802		
1 (X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF GORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECROED BY FULL, REQUEATORY OR LISC IDENTIFYING INFORMATION)		PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
					BEHOLITOT)		
E 244	Continued From page	. 46		314			
7314			ļ · ·	014	'		
		the development of the	1				
	stage 2 pressure ulce	1.					
	When interviewed on	11/17/15, at 2:19 a.m.					
		-B stated she does the					
	weekly measuring and	d assessments of the					
	wounds in the facility.						
		pressure ulcer to his right					
		nd the pressure ulcer has					
	improved, KN-B description and scale guarterly Braden Scale	ribed that the nurses do a			İ		
		nts, but they do not use a					1 1
		essment and added she has					
		of assessment since starting					i i
	in the facility. RN-B o						
		analysis of why R22 had					
		a ulcer. When asked what				-	
		been Implemented for R22					
		thought he was seen by				j	
		wing the medical record					
	•	ate or information regarding				-	
		received, RN-B further are always care planned for				ŀ	İ
		hours unless the frequency				l l	
]		RN-B could not state or				ľ	
	provide documentation		1			ľ	
	assessed for an every					ľ	
		interview RN-B verified that				l l	
	the weekly skin absen	vations were not completed				l l	
		ed for. RN-B also stated that					
		sed in the weekly weight				ľ]
	toss and skin team me	eeting.					
	P22's madical record	acked any documentation					
		oss and skin team meeting					
	discussions.						
						ļ	
	On 11/17/15, at 2:38 p	o.m. RN-H stated the facility					
	does not use a Tissue	Tolerance assessment for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE; SURVEY COMPLETED	
		245227	B. WING			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) IO PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION CARE
F 314	gets instructions on a on the repositioning or from physical or oc When interviewed on occupational therapis	riate Individualized es. RN-H stated the facility dmission from the hospital frequency a resident needs ecupational therapy. 11/18/15, at 7:43 a.m. the t (OT) stated R22 was seen	F	314			
	from 7/30/15 through 8/21/15 prior to the development of the current pressure ulcer. The OT stated R22 was assessed for wheelchair positioning to aid in independent eating. The OT stated R22 had a cushion removed from his wheelchair that had been placed on top of his roho cushion and they adjusted the back of his wheelchair to decrease leaning. The OT stated she was made aware of R22's development of a stage 2 pressure ulcer but did not pick him up for therapy as there isn't anything more therapy could do for R22. The OT further stated that the therapy department can do pressure mapping if requested and ordered but they do not do routine screening for tissue profusion and added that it is a nursing assessment.						
	C replied "That's a reasked how a resident repositioning schedul record and confirmed comprehensive risk a tolerance assessment taught to use the Braden is not a coassessment. On 11/16/15, at 9:35 a						

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING			11/18/2015		
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	в стп	·	1601	EET ADDRESS, CITY, STATE, ZIP CODE I ST LOUIS AVENUE LUTH, MN 65802			
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 314	odor. The edges of th surrounding tissue bla (RN)-B stated the me changed since 11/17/ rounds. The wound had the me changed since 11/17/ rounds. The wound had the me compared on director of nursing (Down and that the nurses updetermine an approprior residents. The DO was repositioned time plan. The DON stated specific tool to assess DON further stated we should be completed. The undated facility Sindicated assessment are completed upon a readmission and daily patient/residents. Requested a policy or ulcers and the facility. R152 did not receive a few development and pulcers. According to the R152 was admitted on neuroendoctine carcin obstruction and significare Area Assessment.	peefy red, without slough or se wound were intact and the anched. Registered nurse asurements had not 15 when she did her weekly ad measured 2.4 cm x 1.2 han 0.1 cm. 11/18/15, at 10:20 a.m. the DN) stated that all residents is repositioning schedule did repositioning schedule. If you according to his care of the facility does not use a stor tissue profusion. The peekly skin observations and documented. It was a the prevention of pressure at the prevention of pressure.		314				

Facility ID: 00589

STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	·········	16	TREET ADDRESS, CATY, STATE, ZIP CODE 801 ST LOURS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XB) COMPLETION DATE
F 314	identified no individual but did identify it would and policies. A progress note dated had mepiplex on his deadmission for "prevent Braden skin risk asset R152 to be at low risk physician progress no skin breakdown. A physician order dat mepiplex (foam dress dressing every 4-7 dat float heels and remind 2 hours. There was no record to correspond physician's order. On directed staff to place absorbent all in one with moisture barrier on the breakdown on the right progress note identification in the right buttock meat 2 cm. A weekly skin at 6/20/15, identified the skin was for skin issues the we broken at coccyx" with There was no further R152. R152 expired on 11/17/15, at 12:58 (RN)-A stated there we documentation availation availation availation availation availation availation absence of the complete results	dated as initiated on 6/5/15, dized interventions for R152 d follow facility protocols d 5/28/15 revealed R152 exceys at the time of stative measures." The sament of 5/28/15, identified for skin breakdown. A site dated 6/2/15, indicated ed 6/17/15, identified ing) to the coccyx - change may and as needed (PRN) - di [R152] to reposition every of documentation in the with the need for the new 6/19/15 a physician order an Optifoam dressing (an evound dressing with a elecution of the skin into buttock. A 6/19/15, ed skin breakdown noted on suring 2 centimeter (cm) by assessment completed into the first of the fi	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLFA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245227	B. WING		11	/18/2015
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 ST LOUIS AVENUE DULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	:	(X5) COMPLETION
F 314 Continued From pal Improve their skin of take specialized workidentified the facility policy wassessments and uneeded. RN-A state finalized for R152 y. On 11/18/15 at 8:33 (DON) stated she in she believed R152 DON further stated for "protection" due break down. She climated she would break down. She climated she would break documentation a we have on the work be "all the document of the documents, the Information provide 483.25(h) FREE OF HAZARDS/SUPER. The facility must enemylment remains as is possible; and adequate supervisite prevent accidents.	ge 53 are and had one of the nurses und care training. RN-A as to complete weekly skin pdate the practitioners as dithe care plan hadn't been at. if a.m. the director of nursing realled R152, The DON stated frever really opened up." The the dressings in place were to R152's high risk for skin arified that dressings are used aplice residents. The DON we to look at R152's record additional information. On and the DON provided copies and stated it was "everything ands." The DON believed it to tation we need." Upon review there was no additional information. ACCIDENT	F 314	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 3. Nurse Managers will audit weekly the skin checks are completed timely for the months. Observations rounds will be conducted by the nurse managers and development to monitor that turning schedules are being performed per the resident's plan of care. 4. Audit outcomes will be discussed at for three months to determine if further education is needed. 5. The Director of Nursing/designed was responsible. Completion date of 12-31-2015.	bat liree staff	
by: Based on observat	оп, interview, and document				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT		(X3) DATE SURVEY COMPLETTED			
		245227	B. WING			11/18/2015		
	(EACH DEFICIENC	B CTR ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1601 DUI	EET ADDRESS, CITY, STATE, ZIP CODE 1 ST LOUIS AVENUE LUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 1. Resident #42 owns his ow	TE :	(XS) COMPLETION DATE	
F 323	assessments were conterventions were deminimize the risk for f (R61) reviewed for fail evaluate the causativities of the causativities	ed to ensure comprehensive impleted and individualized veloped and implemented to alls for 1 of 2 residents is. The facility failed to a factors of resident falls to a factors of resident falls to a factors of resident falls to a factors of resident falls to a factors of resident falls to a factors of resident falls to a swere appropriate. The sed in an immediate jeopardy, fracture) for R61. In alled to ensure side ralls cured for 1 of 1 residents de rails. The design on 10/22/15, for the hospital following a body and hematoma. R61 cant change in condition dization. Upon return, the series R61's multiple changes der to assist in developing ized interventions to angoing falls. The director of confided of the immediate on 11/12/15, at 6:23 p.m. rady was removed on an but noncompliance for scope and severity of a G. I harm that was not use to fractured hip.	·F	323	bed. Resident #42 was interviewed regarding the of the side ralls. Resident unable to turn self or reasside rails due to disease a severe upper extremity contractures. Resident stake only uses the side rails one side of the bed and owith staff present assisting with turns. The opposite rail was removed, which eliminates the safety issue Resident #61 does not has side rail — only an assist be with no history of loosenical. The bariatric beds have be identified with side rails a would have the potential affected, however there is never been an issue identified with our current side rails becoming loose.	e use is ch nd ates on nly g side e. ve a ar, ng. been and to be has		

Facility ID: 00599

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1, ;	PLE CONSTRUCTION G	1''	TE SURVEY MPLETED
		245227	B. WING_		1 4	1/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 56802		171012013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST 88 PRECEDED BY FULL SC IDENTIFYING INFORMAYION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 323	individualized interver the risk for ongoing fa R61's quarterly Minim 9/8/15, identified he windependent when arrithe hallway. On 9/21/hospital with a subdurback following a fall. I hospital on 10/22/15, indicated R61 was set and had no behavior pidentified R61 required one staff for activities MDS also identified R1 transfers was not steastabilize without assist R61 had pain, receive was at risk of falls, and injury. R61's Fall Care Area / 11/2/15, indicated R61 with a history of falls in not address individualitheir efficacy or the need they were checklists or comprehensively assist appropriate interventio data gathered indicate falls, had decreased or devices, and had multiple R61's care plan initiate he was a high risk for the supplemental of the results of	need for additions to the ntions to assist in minimizing ills. um Data Set (MDS) dated as cognitively intact and abulating in his room and in 15 he was admitted to the all hematoma and fractured R61 returned from the R61's MDS dated 10/29/15, werely cognitively impaired problems. The MDS further diextensive assistance of of daily living (ADLs). The 61's balance during dy, but he was able to lance. The MDS identified dipain medication daily, die had a history of fails with Assessment (CAA) dated I was at high risk for falls in the past. The Fall CAA didized interventions in place, and for changes. Risk Assessments ally on 11/12/15, however, containing data which did not less R61's fall risk to ensure ans were implemented. The died R61 was at a high risk for coordination, used assistive	F 32	23		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDS	TIPLE CONSTRUCTION NO	_	(X3) DATE SURVEY COMPLETED		
		245227	B. WING.			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REH A			STREET ADDRESS, CITY 1801 ST LOUIS AVENU DULUTH, MN 55802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORI	R'S PLAN OF GORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)		
F 323	multiple falls with inju "The resident will be the review date." R61's care plan date following intervention encourage use, promensure appropriate for ordered, activities for alarm in bed and who alarm in bed, transfel and back brace. The 11/9/15, following mu motion sensor alarm implemented. Observation on 11/9/ R61 lying in bed with table. The overbed to feet away from R61's was turned off. The I him. Registered nurs motion alarm was tur out of reach. RN-M to and identified it was a changed the batteries alarm to work. On 11/9/15, at 5:20 p found turned off. RN tray and left the room on. When asked to we turned off she stated the alarm was a prob sounding "so we don On 11/9/15, at 6:20 p	continence, diabetes and ries. The identified goal was free of minor injury through did 11/9/15, identified the scall light within reach and apt response to call lights, betwear in use, PT as diversion/distraction, TAB eleichair (w/c), pressure with assist of 1, gait belt care plan was revised on altiple observations of a not being appropriately distraction alarm the motion alarm the motion alarm the motion alarm the motion alarm on the functioning. RN-M is and was able to get the larm the motion alarm was and was able to get the larm the motion alarm was alternative the motion alarm was and was able to get the larm the motion alarm was alternative the motion alarm was alternative the motion alarm was alternative the motion alarm was alternative the motion alarm was it was. RN-A further stated alem as it was always the motion alarm was it was always the motion alarm was alternative the motion alarm was it was always the motion alarm was it was always the motion alarm was the motion alarm was alternative the motion alarm was it was always the motion alarm was it was always the motion alarm was the motion alarm the motion alarm the motion alarm the	F	323			

Facility 1D 00689

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING.			1 11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			160	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(FACH DEPICIENC)	Y STATEMENT OF DEFICIENCIES FENCY MUST BE PRECEDED BY FULL PROPORTION TO THE PROPERTY OF LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIA DEFIGIENCY)		(X5) COMPLETION DATE
	2:13 a.m. identified the fall. R61 stated he was his room and tripped that his head and also a shoulder pain. Another progress note p.m. identified R61 has sitting on the he hit his head. R61 shoulder ball head on the doorknot was not utilizing his were represented by the head on the doorknot was not utilizing his were represented by the head on palpation to be was dizzy, his legs gas call physician directed neurological changes or back. On 9/22/15 at to complained of ringing headache. R61 had in unable to roll or sit up blood pressure dropped 53. R61 was sent to the was admitted with a sheed) and fractured by 10/22/15, at 1:47 p.m. form the hospital. On 10/24/15, at 1:11 administration note incand climbing out of be up walking alone goin alarm was off and did	ress note dated 8/22/15, at e resident self reported a swalking around the bed in on the bed. R61 stated he complained of slight e dated 9/21/15, at 3:51 and fallen and hit his head. It is easier the was in the land hit the back of his er of the bathroom door. R61 alker at the time of the fall. It is easier to monitor for any and increased pain to head to 7:15 a.m. R61 continueding in ears, dizziness, and a coreased back pain and was in bed or ambulate. His east to 94/53 and pulse was ne emergency room and ubdural hematoma (brain back. A progress note dated indicated R61 returned. a.m. a medication dicated R61 was restless and multiple times. R61 was g through his closet. The not sound.	F	323	DETIGENOTY		
	_	10/25/15, at 10:59 p.m. neurological checks due to					

STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245227	B. WING				11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCHDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BR		(XS) COMPLETION DATE
F 323	hallway looking for his on his feet. He had 3 he had one alarm tuck afarm wrapped up in a atarm did not sound. A progress note dated identified R61 was formiddle of the room. A alarms and a motion athe alarms sounded. The nursing progress 9:22 a.m. indicated R1 weight on his right low was complaining of pacomplained on 10/30/significant pain when was sent to the emergadmitted with a right afarmur) fracture. R61 manure fracture. On 11/12/15, at 2:45 the surveyor to be sittly wheelchalr. R61 was closed. No alarms we discovered on his foot to the room, LPN-A and alarms sounding a within reach. An incident note dated indicated R61 slid out being held onto by R1 and was not quite on the surveyor to the sittle with the surveyor to be sittle wheelchalr. R61 was closed. No alarms we discovered on his foot to the room, LPN-A and alarms sounding a within reach.	R61 was up walking in the stogs. R61 was unsteady atarms in ptace, however, ked in his pants pocket, one a blanket, and the third of 10/29/15, at 6:18 p.m. and on the floor in the lithough R61 had 2 TAB afarm on the floor, none of note dated 10/31/15, at 6:1 was unable to bear ver extremity (RLE) and ain. Staff reported R61 15 as well. R61 had up in the wheelchair. R61	F	323				

	ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	:	245227	B. WING,			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		10	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE IULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCILLENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		(X5) COMPLETION DATE
	practical nurse (LPN) the mechanical lift. R61's falls were review nursing (DON) on 11/DON indicated the fall the recliner with no injury was independent with there were no specific that time. The DON stated the number R61 fell in his bowent to the side of the self-reported the fall. I walker and there was reported he hit the barbathroom door knob. Sure when the TAB all Other interventions in physical therapy (PT) reach, appropriate for assist of one, gail belt The DON indicated with 10:30 a.m. he was four roommate's bed. The DON stated R61 had and he was confused, motion sensor alarm with DON further stated be on 10/29/15, alarms with interventions. The DO "trying to manage his restlessness may hav difficulty expressing points."	nair. RN-B and licensed A returned R61 to bed with wed with the director of 12/15, at 3:58 p.m. and the l of 8/22/15, was a slip off iury. The DON stated R61 ambulation at that time so interventions for falls at mext fall was on 9/21/15, athroom, got himself up and bed. The DON said R61 R61 was not using his no obvious injury. R61 ck of his head on the The DON stated she wasn't arm was placed on R61. place at that time included: to evaluate, call light within but wear, and transfer with the, and back brace on. then R61 fell on 10/25/15, at and crawling toward his fall was unwitnessed. The gripper socks on at the time the DON Identified a was added at that time. The alween this fall and the one were the only additional the also indicated staff was pain" as they felt the the been related to his ain.		323			
	The DON stated R61	also fell on 10/29/15, at					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245227	B. WING.	lil		11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	& CTR		STREET ADDRESS, CRY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DISPICIENCY)	ANTO BE		(XS) COMPLESION DATE
F 323	when R61 was found. wrapped up in his bla were no new interven stated she did not bel result of the fall becauproblem until 2 days at The DON went on to the pedais of his when not believe that was a slipped off the chair. It explain how R61 slipp When asked about reinterventions, the DOI over to answer specification of the pressurasked for a pharmack medications. A requestor a reassessment. Fithe alarms not sound in not aware there had be about an interdisciplinassessment of the fall cause of the falls, the interventions and idermay be appropriate to falls, both the DON and done that. An interview on 11/9/therapist (PT)-A ident 10/22/15, to 10/30/15 current. PT-A said when the state of the fall of the control of the fall of the falls.	e alarms were sounding. The TAB alarm was nket. The DON said there tions at that time. The DON ieve the hip fracture was a use R61 did not report the after the fall. say when R61 was found on elchair on 11/12/15, she did in fall. The DON stated R61 However, the DON could not be do out of the wheelchair. Viewing the specific fall invited the nurse manager ic questions. 11/12/15, incident she did alarm in R61's wheelchair sheet) on the top and the pad. RN-A also said they st review of R61's st was also sent to therapy RN-A was informed about ing and indicated she was been issues. When asked hary team comprehensive its to determine the root	F	323			

	OF DEFICIENCIÉS CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	1		CONSTRUCTION		SURVEY PLETED
		245227	a. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	BCTR		16	TREET AUDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFFX YAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	١	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(Xb) COMPLETION DATE
	came back from the h subdural hematoma in all three disciplines (p speech) to assess and staff saw R61 for eigh ambulate him but he distated R61 had a lot of fracture. PT-A stated it services was on 11/3/hospital with the aceta another fall. R61's ord as tolerated. Therapy (Transcutaneous Electronic for his pain. PT-A a 10/f0 and staff coult expressions when he expressions when he expressions when he expression on 11/6/15, said they changed his because it didn't fit him kept sliding off the leg they put a calf pad in particular put a calf pad in particular put a calf pad in particular put a calf pad in particular put a calf pad in particular put a calf pad in pat a calf pad in pat put a calf pad in pat put a calf pad in pat put a calf pad in pat put a calf pad in pat put a calf pad in pat put a calf pad in pat put a calf pad in pat put a calf pad in pat put a calf pad in pat put a calf pad in pat put put a calf pad in pat pad pat put a calf pad in pat put put a calf pad in pat put put put a calf pad in pat put put put put put pat put put put put put put put put put pu	ospital following his in 10/15, he had orders for hysical, occupational, and ditreat. PT-A stated therapy it days. Staff attempted to could not ambulate. PT-A of pain due to his back the next request for lherapy 15, after returning from the abulum fracture from lers were for weight bearing staff utilized an TENS strical Nerve Stimulation) stated R61 rated his pain at ditell by R61's facial was in pain. Wide on 11/12/15, at 12:45 sical therapy did an apost fall with injury, she wheelchair at that time in well. PT-A was aware leg of the wheelchair. She said place that morning. If J on 11/13/15, updated is fall care plan included the abserved to be any, or staff were not the changes. The resident's needs, ent unattended when up in post falls and attempt to	F	323			

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-	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	REET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE BLUTH, MN 55802		
(X4) ID PREF2X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PROCEDED BY FULL LSC IDENTSFYING INFORMATION)	(D PREFD TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(XS) COMPLETION DATE
F 323	Educate resident/fam Provide diversion and music, socials and sp Offer a snack (food at states he's hungry or effectiveness. PT evaluate and treat The resident uses TA and w/c. Pressure alson top and bottom of During an interview of trained medication at had one pressure alarm in his. An observation on 11 was sitting by the nurwith his TAB alarm or nearby activities programmer to the documentation identification and the documentation identification and the documentation identification and the documentation identification and changes to Round the documentation identification and changes to Round the documentation identification and changes to Round the other hall but, "I keyelling in pain."	ential causes if possible. illy caregivers/IDT I distraction such as news, ecial events. Indid drink) when restless, unable to sleep and monitor It as ordered. Belectronic alarm in bed farm in bed and w/c. Dycem pressure mat in w/c. In 11/13/15, at 8:17 a.m. esistant (TMA)-K stated R61 Im in his chair and a bed. I/13/15, at 10:00 a.m. R61 ses station in the hallway In but not in attendance at the Iram. I/13/15, at 11:28 a.m. I/13/15, at 11:28 a.m. I/13/15, at 11:28 a.m. I/13/15, at 10:00 a.m. R61 I/13/15, at 11:28 a.m. I/13/15, at 11:28	F:	323			

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	1 ' '	TPLE CONSTRUCTION VG	_		E SURVEY IPLETED
		246227	B. WING.		,	11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, C 1601 ST LOUIS AVE DULUTH, MN 5580			
(X4) ID PREFIX TAG	(EVCH DELICIENC.	ATEMENT OF DEFICIENCIES Y MUST RE PRECEDED BY FULL LSG IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIA DEFIGIENCY)		(X6) COMPLETION DATE
F 323	has alarms in his chainot aware of any new yesterday. An interview on 11/13 family member (FM)-H September he slipped R61 told FM-K he waget help. FM-K stated R61's mind was clear. An interview on 11/16 stated, "I didn't know the has a back brace and his back brace any changes in his pladays NA-G was aware chair and his bed. During an interview with p.m. stated the change included: alarms in the when up he needs to be	on fall precautions, so he ir and a TAB alarm. She was plan of care since /15, at 11:06 a.m. with Cindicated when R61 fell in the bathroom. as tired of waiting so long to diprior to his head injury, /16 at 3:43 p.m. NA-G he fell. He is in a lot of pain, and is a full mechanical lift." he hadn't been informed of an of care in the last couple a he had alarms on his h RN-D on 11/16/15, at 3:47 in R61's plan of care wheelchair and bed, and e ln the dining room or by	F:	123			
	wheelchair and a press was education for staff signed after receiving the An interview with RN-A stated staff placed a prealarm in his bed and while fit unattended while in engaged in activities. TR61's medications and well. The physician order	on 11/16/15, at 4:07 p.m. essure pad and and a TAB neelchair. R61 was not to be the wheelchair. He is to be he pharmacist reviewed the medical doctor will as ered a scheduled a pain er stated she has seen R61 eed he did not have					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI		ECONSTRUCTION		E SURVEY PLETED
		245227	B. WING		101000	11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		,	11	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE IULUTH, MN 56802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(D PREFI) TAQ	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X9) GOMALEHON BATE
F 323	staff should be using they are not. She sald pharmacological pain should." RN-A stated doesn't have good pa R61's pain may be af staff requested a regunew pain order is for daily. Interview on 11/16/15 indicated they change falls to include a weel PT, to review all high committee will review are in place and all of fall risks. An interview on 11/13/15. It hings independently, planned 1:1's. The testall meetings and she An observation on 11 was doing therapy for about his wheelchair agreed and said "the tengthened a little." That that time. An interview on 11/17	the same pain scale and the same pain scale and they do not us any non interventions and "we since survey started R61 in control. She further stated fecting his restlessness so that pain medication. His oxycodone 10 mg 3 times oxycodone for oxycodone including the medical for oxycodone including the said oxycodone oxycodone including the oxycodone		323			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		245227	B, WING_			11/18/2015
	ROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF PEFICIFINGIES CY MUST BE PRECEDED BY FULL R I.SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD:BE	(XS) COMPLETION DATE
F 323	the pharmacist and recommendations replace. An interview on 11/2 said she had accider she started but not with the started but not with the started but not with the immediate jeopa was removed on 11/2 implemented the foliominimize the risk of the noncompliance remassive for the property jevel of G - in level, which indicated immediate jeopardy. Actions taken to remain verified through observed review were a 1. Comprehensive for completed. 2. Physician orders for (BMP) and urinallysis 3. R61 was not left a observations. 4. R61 was included sessions. 5. Alarms were in placed. 6. NA care sheets with the NAs. 7. Care plan was up 8. The medication a records were updated 9. The pharmacist an recommendations were	7/15, at 12:24 p.m. RN-A said medical doctor's egarding R61's falls were in 17/15, at 12:39 p.m. RN-F at investigation training when with in the last couple months. andy that began on 10/22/15, 18/15, when the facility owing interventions to falls for R61. However, ained at the lower scope and solated, scope and severity diactual harm that is not for R61. Hove the LI, which were ervation, interview and as follows: all risk assessment was for a Basic Metabolic Profile is were completed, alone in his room during thin more activities and 1:1 ace in the wheelchair and in the ere changed and signed by adated, and treatment administration as ordered.	F F	23		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLAA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		246227	B. WING			11/	18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	BCTR		16	REET ADDRESS, CITY, STATE, ZIP CODE 301 ST LOUIS AVENUE ULUTH, MN 55802			
(X4) ID PREFIX TAQ	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 323	with high risk resident weekly IDT meeting. On 11/13/15 at 2:01 pundated Root Cause prevention policy. The the daily standup meeting on safety, fadevices, care plan adgroup sheets that direcare." The facility policand Chair" reviewed not substitute for properties of the same reviewed and compared to the side R42's quarterly MDS R42 was cognitively in assistance with bed multiple diagnoses in R42's care plan dated used side rails as ord safety while in bed and The care plan directed or entrapment related. On 11/10/15, at 9:28 a.m. R42's right side in checking for the function word freely up and pulling on the side rails.	ents will be done quarterly to being focused on at the own, the DON confirmed the Analysis Authors was the fall expolicy Identified, "During eting falls are discussed if risk, fall management, justments and updates to ect the non-license staff cy entitled, "Alarms for Bed 10/14 Indicated, "Alarms do er care and supervision." as not secured to prevent erail. dated 9/25/15, indicated nobility. The MDS included cluding quadriplegia. if 10/1/15, indicated R42 ered by the physician for ad to assist with bed mobility. It describes the following to the physician for a staff to observe for Injury	F	323	A. All safety interventions for residents have been added to for licensed staff to assess an document that those interventions are in place and working profits. B. Safety care plans have been reviewed along with CNA casheets for appropriate interventions by 12/18/15. C. A new fall assessment was for all current residents. Completed F1/13/15. D. All residents will have a fassessment on admission or readmission, quarterly and following any fall or significate change. This is ongoing. E. the Director of Nursing/designee is notified immediately of any fall. F. Interventions are reviewed revised as necessary. G. IDT meets Monday through Friday assessing any new fall review and recommend interventions as necessary, and will update care plan as need if IDT meets weekly to discursidents considered high rist falls, care plans reviewed, effectiveness discussed and updated as needed.	TAR d to tions perly. en are s done all ant l and gh ls, ad ed. ass all		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLFA IDENTIFICATION NUMBER:	l		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015
BAYSHOF		ATEMENT OF DEFICIENCIES		16 D	FREET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	right side rail was too reported it to staff the On 11/17/15, at 7:21 a observed to be tighter a gap. When interviewed on D stated that the side and when R42 reports put in a maintenance NA-D verified that the tightened, but was not when interviewed on director of maintenance rails for R42's were the added, they do located the facility does place to routinely checkide rails. The facility policy Bed directed maintenance	a.m. R42 verified that the loose for him and he had day on 11/11/15. a.m. the right side rail was ned up. There was no longer 11/17/15, at 9:24 a.m. NA-rails become loose at times she did not feel safe, staff ticket to have it tightened. right side rail had been to sure when. 11/17/15, at 3:43 p.m. the ce (DM)-B stated the side ne correct rails for the bed. Seen up with use. DM-B so not have a process in ck the safety and function of	F	323	I. any side rails will be che weekly to determine that are properly attached to by maintenance. II. Nursing staff will be inserviced on fall, and fa prevention DON will review all falls and fall foll up to assure above is completed. 4. DON will report to QAPI monthly determine any trends, patterns or issue with current fall policy. This will be orgoing. 5. The Director of Nursing/designee we responsible. Completion date of 12-31 2015.	they bed II ow to ss n	
			FS	325			
	` '	ty must ensure that a ble parameters of nutritional veight and protein levels, clinical condition			 Resident # 158 was not affected by alleged deficient practice. Resident is currently stable, MD has determined the resident's weight loss is unavoidable not cancer diagnoses All residents have the potential to be affected by the alleged deficient practice. 	iat clated	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`'		DNSTRUCTION		SURVEY PLETED
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1601	EET ADDRESS, CITY, STATE, ZIP COOR ST LOUIS AVENUE LUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ED PRÆFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION CATE
F 325	Continued From page (2) Receives a therap nutritional problem.	68 eutic diet when there is a	FS	325			
	by: Based on observation						
	Findings Include:						
	(MDS) dated 9/30/15, diagnoses of cancer a further identified R158 cognitive impairments	and dementla. The MDS 3 had moderate 5, and was independent p assistance, and a 5%					
	75% of food at meals w served. The assessme had vision impairments	had an average intake of vith regular portions being nt elso indicated that R158 and was a low nutritional onal interventions Included					
	dated 9/30/15, indicate due to a poor memory, of daily living without si and weight loss. The gr	Area Assessment (CAA) d R158 was a nutritional risk Inability to perform activities gnificant physical assistance oal listed on the CAA was tive measure and a care ed.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION		ATE SURVEY OMPLETED	
		245227	B, WING			11	/18/2015	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CHY, STATE, ZIP CODE			
BAYSHOR	RE RESIDENCE & REHA	B CTR		-	601 ST LOUIS AVENUE PULUTH, MN 66802			
(X4) FD PREFIX T'AG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTION (IFACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(XI) COMPLETION DATE	
	restrictions, weight los Interventions included provide and serve di monitor intake and monitor intake and monitor intake and monitor intake and monitor intake and monitor intake and monitor an order for a regular dilacked an order for a monitor for for a monitor for a monitor for for a monitor for for a monitor for for a monitor for for a monitor for for a monitor for for a monitor for for a monitor for for a monitor for for a monitor for for for a monitor for for for for for for for for for f	d 10/9/15, indicated sutrition secondary to fluid as and infection problems. It is as ordered ecord every meal ower day as dated 11/10/15, included ist. The physician orders sutritional supplement. Itals Summary Included (Ibs) -10% weight change weight change weight change weight change would be a supplement of the breakfast meal. Itals was observed to the breakfast meal. Itals a sup of a cup of coffee. During the	F	325				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTÍFICATIÓN NUMBÉR:	1 ' '		E CONSTRUCTION	COMP	SURVEY PLETED
		245227	B, WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			10	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	8 PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REPERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325	throughout the meal and her toast, staff did sugar or raisins on he meal R158 stated "I dencouraged by the state R158 at 75% of hot toast, leaving the crus of coffee, 1/2 of her mR158 stated "I've had On 11/17/15, at 12:23 eating independently lunch meal. R158 wawith whipped topping 8 ounces (oz) of milk ate 100% of the orang and only bites of the toom. R158 drank 100 During the observation with her dining room the pick up her fork and rathen put the fork back herself from the dining herself back to her room the stated R158's intake it every shift for further of how much R158 at When interviewed on registered nurse (RN) determined if a nutrition.	al of 3 cups during being encouraged to eat and was assisted to put jelly not offer to place brown or hot cereal. During the ion't do eggs" when aff member to eat. The staff R158 an alternative food, cereal, bites of eggs and her at. R158 consumed 3 cups hilk and no orange juice. enough." 8 p.m. R158 was observed in the dining room for the asserved a cup of oranges, tace hotdish, Mexican corn, and 8 oz of coffee. R158 ges and whipped topping acc hotdish and Mexican 194 of her milk and coffee. In R158 was busy playing ticket and would frequently not take a bite of food and a down. R158 then pushed groom table and propelled om via her wheelchair. 11/18/15, at 9:12 a.m. 1-L. stated that every meal is computer kiosk. NA-L also is reported to the nurse on documentation regardless e at the meal.	F	325			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CBA IDENT/FICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			16	REET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 325	registered dietician (Research to weights and food intains the dietician. The RD has a decline in weight resident would be reaprevent further weight was a difficult case, a however, the RD state the dying process. Uppersonal spreadsheet stated R158 was not I weight as the RD repostarting weight as 123 RD stated the starting her admission weight The RD stated that she RD stated that she RD stated that she	utritional supplement. 11/18/15, at 9:05 a.m. the (D) stated residents are to at a minimum, and resident's kes are reviewed monthly by further stated if a resident and food intake, the ssessed for interventions to closs. The RD stated R158 as she was on hospice care, and R158 was not actively in non review of the RD's of residents weight the RD tooked at for a decline in orted she entered R158's and food	F	325	 The Registered Dietician will followeight assessment and intervention gaidelines. This will be engoing. Registerian will continue to work with notaff regarding weight frequency and up. This will be engoing. Weights will taken weekly. Registered dictician will review we weekly to determine any significant of and will communicate with the IDT to determine appropriate interventions. Vecontinue to work with Wound and we committee weekly. Registered dietitist report to QAPI monthly on all significating findings. The RD/designee will be responsible oversight from the Administrator. Completion date of 12-31-2015 	gistered ursing follow- I be ights hanges, Will ight an will cant	
	Intervention undated of review the month to follow inditine. Negative trends treatment team wheth significant weight characteristics (2) RESIDE SIGNIFICANT MED ETHE facility must ensurany significant medical	NTS FREE OF RRORS re that residents are free of	F3	333	1. Resident #109 has had no ill effects alleged deficient practice. 2. All residents would be considered a from alleged deficient practice.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION		SURVEY PLETED
		245227	B. WING			11.	18/2015
	RDVIDER DR SUPPLIER RE RESIDENCE & REHA		•	160	REET ADDRESS, CITY, STATE, ZIP CODE IN STILOUIS AVENUE ILUTH, MN 56802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT DE DEFICIÉNCIÉS Y MUST BE PRECEDED BY FULL LSC (DENTIFY)NG INFÓRMÁTIÓN)	IO PREFIX TAG	`	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	facility falled to ensur-was free from a signification of the findings include: R109's Admission Resthat included Alzheim R109 was place on hilling services due to Al. The physician's order morphine sulfate soluby mouth every 1 houbreath pain (2 mg equilibrium). A review of R109's profolowing: On 1/1/15, an entry in medication aide (TM/supervisor on day shin narcotics record book 12/28/15, R109 receiliquid morphine. R109 mg was the equival R109 was given 2 mt. ordered. On 11/17/15, at 9:42 (RN)-C was interview working at that time, a medication error. On 11/18/15, at 11:23 (DON) was Interviewed.	and document review, the all of 1 residents (R109) icant medication error. cord identified diagnoses er's disease. On 12/2/14, ospice services for end of zheimer's disease. s on 12/28/14, directed tion, give 2 milligrams (mg) in as needed for shortness of uals 0.1 milliliters [ml]). ogress notes indicated the indicated per the trained (a) and the nursing fit, and after researching the interest dose of (a) was prescribed 2 mg, and ent of 0.1 milliliters (ml). 20 times the amount a.m. registered nurse ed, and stated she was not and was unaware of the call and stated she reviewed the Quality Assurance (QA)	F	33			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION		E SURVEY IPLETED
		245227	B, WNG			11	/18/2015
	(EACH DEFICIENC	B CTR ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	16 D	REET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 55802 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		0X5} COMPLETION PATE
F 356	the medication error in 11/17/15, at 12:40 p.m. coordinator (AC)-H state the medication error in the facility policy and Consequences and Mindicated a medication preparation or adminitiologicals which is nephysician's orders. The interdisciplinary team medication regimen for potential medication-rongoing basis. 483.30(e) POSTED NINFORMATION The facility must post on a daily basis: o Facility name, on The current date, on The total number are worked by the following and unlicensed number are worked by the following and unlicensed number are vocational numbers (as one certified numbers as one Resident census. The facility must post to the facility post to the faci	ested to provide a copy of investigation form. On in, the admissions alted she was unable to find investigation. procedure on Adverse ledication Errors dated 2/14, in error is defined as the stration of drugs or of in accordance with the repolicy directed the to review the resident's or efficacy and actual or elated problems on an URSE STAFFING the following information ind the actual hours and categories of licensed grategories of licensed grategories of licensed effined under State law), ides. the nurse staffing data ally basis at the beginning of eposted as follows:		333	3 .Licensed staff and TMAs will complete medication administration reeducation 12/18/15. The transcription process is currently being audited for all new admission and readmissions. This is or going. All medication errors will be reviewed by Nurse Managers and DOI corrective reeducation will be done as as review is complete. This is ongoing 4. Medication error trends and or path will be reported to monthly QAPI committee. This will be on going. The transcription process is being reported the monthly QAPI committee, This will obtain process. 5. The Director of Nursing /designee were sponsible. Completion date of 12-31 2015. 1. No residents were affected by the all deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice.	n N, soon soon to libe will be	

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	UF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(XS) DATE SURVEY COMPLETED	
		245227	a. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	BCTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUT H, MN 66802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUEL SCIDENTIFYENG INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFFCIENCY)		(X5) COMPLETON DATE
F 356	make nurse staffing d for review at a cost no standard. The facility must main staffing data for a min required by State law, This REQUIREMENT by: Based on interview a facility failed to ensure included the actual hor This had the potential residing in the facility. Findings include: A review of the direct facility staffing schedul 1/16/15, indicated pastaff on 13 of 15 days postings for each date hours worked during to director of nursing (DC were not included on the staff posting to the	readlly accessible to n oral or written request, ata available to the public at to exceed the community tain the posted daily nurse imum of 18 months, or as whichever is greater. is not met as evidenced and document review the a the nurse staff posting burs worked for partial shifts, to affect all 159 residents care staff posting and the attention of 11/2/15, through artial shifts were worked by The direct care staff add not specify the actual	F:	356	3. The posting of actual nursing hours lowered so as to be at a level height for wheelchair residents. Hours posted imported hours worked, which include pashilts. 4. An audit will be conducted two (2) per week times 12 weeks to monitor the actual hours, including partial shifts a recorded and posted on the nurse staff posting. Audits will be presented to the monthly QAPI committee to assure compliance with posting of actual hours worked. After three months the QAPI committee will make a recommendation to the need to continue to monitor the posting of hours. 5. the Administrator/designee will be responsible. Completion date of 12-31 2015.	or clude artial times nat are clude ars lon as	

FORM CMS-2687(02-99) Previous Versions Obsolete

Fac@iy ID: 00589

	OF DEFICIENCIES CORRECTION	(X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		246227	B. WING		11/18/2015
	ROVIDER OR SUPPLIER	B CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	
(X4) ID PREFIX 1'AG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY PULL USC (DENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFORENCED TO THE APPROPRIA DEFICIENCY)	
F 356	staff posting was 59 in	o.m. the DON verified the nches from the floor to g, and was not at a height or anyone seated in a	F 350	5. The Administrator/designee will be responsible.	
	483.60(c) DRUG REGIRREGULAR, ACT OF The drug regimen of a reviewed at least once pharmacist. The pharmacist must the attending physicial nursing, and these reputations. This REQUIREMENT by: Based on interview at facility failed to ensure	is not met as evidenced is not met as evidenced is not met as evidenced is consultant pharmacist is promptly addressed for R109) reviewed for	F 428	1. Resident #38 has had no advill effects due to the alleged deficient practice. Resident / less anxious and has minima attempts at trying to remove ostomy bag with current medications. Appetite is impand she is participating in ac Resident # 109 has had no ac of ill effects due to the allege deficient practice. Resident i demonstrating less grimacing moaning, less arching and le grinding of teeth, which has improved his quality of life. 2. All residents have the pot to be affected by the deficient practice.	t38 is I her roved tivties, Iverse ed s g, Icss ss
	that included colostom with mixed anxiety and dementia, delusional of psychotic disorder, R3	8's quarterly Minimum 9/11/15, indicated she e impairment, and			

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STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MURT A, BUJLON	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245227	B. WING_			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		•	STREET ADDRESS, CKTY, STATE, ZIP 1601 ST LOUIS AVENUE DULUTH, MN 55802	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEND	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN DE (EACH CORRECTIVE AC' CROSS-REPERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(XE) COMPLETION CATE	
F 42 8	R38's order summary indicated R38 receive antidepressant medic by mouth in the more obsessive compulsive adjust disorder with rimood; the start date report also indicated furnarate (an antipsystwice a day for parandisorder with a start of R38's order summary antianxiety medication needed for anxiety reand 0.25 mg by moute and 0.25 mg by moute and one of the received rec	r report, dated 11/18/15, ed sertraline HCl (Zoloft) (an eation), 200 milligrams (mg) ing for anxiety with e disorder (OCD) related to nixed anxiety and depressed was 8/15/14. The order R38 received quetiapine choic medication), 50 mg oia retated to delusional date of 8/16/13. In addition, r indicated lorazepam (an en) 0.5 mg by mouth as elated to delusional disorder the two times a day for anxiety a disorder with mixed anxiety.	F	428			
	problem related to lor multiple times a day, type behaviors. The had a mood problem dementia, delusions, The care plan directe observe/record/repore pisodes or feelings and interest in activiti interactions with residuhen she is receiving A 6/19/15, Consultan Review form indicate R38's sertraline (Zoldirregularity comment benefit analysis/docupsychotrople medicar	and cognitive impairment. If d staff to It to the physician any acute of sadness, loss of pleasure ies, and to have positive dent at times other than If medical care. If Pharmacist's Medication If an irregularity regarding					

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION		TE SURVEY MPLETED
		245227	B. WING			1 4	1/18/2015
NAME OF PI	ROVIDER OR SUPPLIER	ZASELI		STRE	ET ADDRESS, CHTY, STATE, ZIP CODE		17 10/2010
BAYSHOE	RE RESIDENCE & REHA	S CTR		1601	ST LOUIS AVENUE		
DRIGHT	TE REGIDENCE & REIF			DULI	UTH, MN 66802		
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F 428	her ostomy bag. Since that has improved, the is recommended at the analysis/documentation suggested course of a versus benefit statem continuation of the Zo	past history of focusing on the starting this medication, erefore, no further reduction his fime-still risk vs. benefit on is required by CMS. The faction was to provide a risk ent and clinical rationale for bloth as ordered. A hand	F.	128			
	psychiatrist. The sign The 10/20/15, consult comment requested a statement for the sert clinical rationale for or guidelines. Under the section "rejected" is of written note indicated this time. Benefits our signature is not legible on 11/17/15, at 2:07 p	tant pharmacist irregularity irisk versus benefit rallne medication, including continuation, per CMS collow-up or action taken ircled and a 10/29/15, hand reduction not indicated at rrently outweigh risks. The collow-up, in an interview					
	R38 was observed an 3:20 p.m., sitting calm R38 made eye contact interacted appropriate R38 was observed on again at 8:10 a.m., ca floor dining room with On 11/12/15, at 8:53 adoorway of her room v On 11/12/15, at 12:24 R38 was observed in 11/15/15, at 8:00 a.m.	d interviewed on 11/9/15, at lay on the edge of her bed. It, answered questions and lay throughout the interview. 11/12/15, at 6:55 a.m. and lamly sitting in the second a beverage in front of her. It is a.m. R38 was in the with a smile on her face. and again at 12:45 p.m.					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245227	B. WING _			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		160	REET ADDRESS, CITY, STATE. ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFECIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH GORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 428	In an interview on 11/2 stated she doesn't kn brother is her respons doesn't feel like she had brother is her respons doesn't feel like she had be assistent (NA)-J state gowns, towels and ot colostomy bag off. NA set-up and stand-by a but is independent wi stated they have not anything else. In an interview on 11/2 registered nurse (RN) June 2015, medication practitioner's who routed in an interview on 11/2 stated R38 just started psychiatrist in Octobe 2015, response refer psychiatrist in Octobe 2015, response refer psychiatrist, who did RN-G stated the hand was from the consultated practitioner. RN-G stated the nup a formal risk versurequested from a phy they don't review it with the state of the state of the state of the nup a formal risk versurequested from a phy they don't review it with	two others at the dining rages, waiting for breakfast. 117/15, at 8:44 a.m. R38 ow her medication, but her sible party. R38 stated she has any side effects from her is that they help her. 117/15, at 8:56 a.m. nursing at R38 does hoard sugar, her items; R38 also pulls her ray stated R38 required has assist with personal hygiene, the other cares. NA-J also been told to watch for 117/15, at 2:00 p.m. 117/15, at 2:00 p.m. 117/15, at 2:07 p.m. RN-G divisits with the consultant has at the facility. 117/15, at 2:07 p.m. RN-G divisits with the consultant has see R38 until October. It will be a consultant had see R38 until October and psychiatrist's nurse atted they (the consultant hurse practitioner) don't type has benefit when it's sician. RN-G also stated the residents.	F 42	28	3. The following systems will implemely 12-31-2015 Pharmacist makes recommendations and emails ADON along with DON ADON prints off recommendations, signs, and distributes to appropriate nurmanagers Nurse Managers fax appropriate places in rounding book for Eldercare and Dr. Gish reside Nurse Managers follow throut mursing recommendations from pharmacist As recommendations are addressed by provider and managers are addressed by provider and managers in resident chart and copy is good back to ADON. Original is point resident chart and copy state with ADON ADON uses the "nursing drup report" emailed by consultant pharmacist to check off recommendations that have to back from the nurse manager cusures that the provider responsing appropriate.	se iate rs or ents,	

	OF DEFICIENCIES COMRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	_	(XS) DATE COME	SURVEY PLETED
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	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	ID.	STREET ADDRESS, CITY 1601 ST LOUIS AVENU DULUTH, MN 55802	IE		OVE.
PREFIX TAG	(EACH DEFICIENC)	Y MUST 85 PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORI	RESTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	In an Interview on 11/consultant pharmacist for the lapse of time be when no action was to pharmacist stated that versus benefit on the adequate risk versus in his notes, which wo the medical record. Note that included recommen pharmacist, and the fact R109 had recommen pharmacist, and the fact R109's Admission Received from the fact R109's Admission Received from the fact R109's Admission Received from the fact R109's Admission Received from the fact R109's Admission Received from the fact R109's Admission Received from the fact R109's Admission Received from the fact R109's physician's order, depressing, each yelene, bathing and if R109's physician's order, depressing for Ativan (an antianxiety (mg) twice a day. Risperdal (an antidepressibedtime. On 8/25/15, the consultation of the I Ativan, Risperdal, and medications improve times.	18/15, at 10:23 a.m., the istated he cannot account etween June and October aken. The consultant is in his opinion the brief risk October form was an benefit and that the a more detailed description uld not yet be available in additional information was lity. dations from the consultant acifity did not act upon them. Cord identified diagnoses er's disease, anxiety hypertension, gout and Minimum Data Set (MDS) and R109 had severe and required extensive to ff with bed mobility, sting, mobility, personal colleting. Lers indicated the following: medication) 1 milligram shotic medication) 25 mg at litant pharmacist gave the ant medication 25 mg at litant pharmacist gave the covest effective dose for the Zoloft as well as how these he residents quality of life. Aysician responded with the	F 4:	ADON will re and de is need review by rev recomm ADON that fir provid 4. Any negative to the consultin Any issues with will be discusse committee. Any MD responses t Medical Directo attending physic timely. System 5. The Director responsible with	N and consultant pharmoview questionable respected if further clarificated. Pharmacist will also past due recommendation report with N. Decision will be made as to readdress with ler or Medical Director coccurrence will be reported at the monthly QAPI you going issues with the Facility will contact or to facilitate having the cian respond back more will be on going. Tof Nursing/designee with oversight from the Completion date of 12-	tionses tion so tions the de at corted tely. the the the	

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245227 B. WING		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	11/18/2015	
BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802		
PREFIX (EACH DEFICIENCY XUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X6) COMPLETION DATE	
F 428 Continued From page 80 Risperdal, Question effectiveness, question if experiencing symptoms. The physician's response lacked documentation of how these medications improved R109's quality of life. On 11/17/15, at 8:03 a.m. registered nurse (RN)-G was interviewed, and stated the consultant pharmacist comes to the facility monthly, and she reviews the recommendations with him. On 11/18/15, at 11:59 a.m. the director of nursing (DON) was interviewed, and stated the assistant director of nursing reviews the consultant pharmacist recommendations with him, and the DON was told there was not a problem with them. The facility was unable to provide a policy and procedure on consultant pharmacists recommendations. F 431 483.80(b), (d), (e) DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation: and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.		

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	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPCIER/CLIA IDENTIFICATION NUMBER:	1	FG	(X3	O DATE SURVEY COMPLETED		
		245227	B. WING_			11/18/2015		
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 66802	A1/18/20 CITY, STATE, ZIP CODE ENUE 02 IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD SEE			
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F 431	Continued From pag	e 81	F 4:	31				
	facility must store all locked compartments controls, and permit a have access to the kill. The facility must provipermanently affixed a controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when package drug distributed.	tate and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to eys. And the separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and and other drugs subject to the facility uses single unit ation systems in which the timal and a missing dose can						
	by: Based on observation review the facility fails stored at the required medication refrigerate failed to provide secular the first floor nurse. Findings include: On 11/13/15, at 9:25 medication refrigerate observed to be 32 dethermometer and 29 thermometer. The but	a.m. the Morning Light West or temperature was grees Fahrenheit (F) on one						
	into the refrigerator. A log Indicated the acce	A review of the temperature eptable range was 36-46 emperature had been within						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		SURVEY PLETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	в стя		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE IJLIJTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUEL LSC IDENTIFYING INFORMATION)	(D PRSF3) TAO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X6) COMPLETION DATE
F 431	indicated the facility of refrigerator temperature in the temperature in the momentum and 29 of the manufacturer's prinsulin stored in the directed the following. Unopened Novolog size frigerator between 3 degrees Figerator at 36 degrees Figerator and should been frozen. Unopened Humulin Nize frigerator at 36 degree frigerator at 36 degrees frozen. Unopened Humalog ship frefrigerator at 36 degrees frozen. Unopened Humalog ship frefrigerator at 36 degrees. The refrigerator contain opened resident intition diabetes) pens: R1 7 Lantus pens. R1 7 Lantus pens. R1 8 Jantus pens. R1 9 Lantus pens. R1 9 Lantus pens. R1 1 Humulin Niper. R1's signed physician included a diagnosis with diabetic peripher.	days. The temperature log thecked the medication ares once daily. Licensed -C verified the frost build up was 32 degrees F on one degrees F on the other. ackage Inserts for the medication refrigerator: thould be stored in a 36 degrees F and 4	F	431			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		246227	B, WING			11/18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1	STREET ADDRESS, CITY, STATE, ZIP COUE 601 ST LOUIS AVENUE DULUTH, MN 55802		:
(X4) ID PREFIX 1AG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 431	included a diagnosis of complications. The phroper inject subcutaneous solution two times dail R87's signed physicial included a diagnosis of complications. The phroper inject subcutaneous solution in the morning scale dose up to 8 uniorders also directed s 10 units of Lantus solution in the morning scale dose up to 8 uniorders also directed s 10 units of Lantus solution ever inject 17 units two time orders also directed s 10 units of Lantus solution ever inject 17 units two time orders also directed s 10 units of Lantus solution daily units subcutaneously. When interviewed on registered nurse (RN) insulin from the medic contact the pharmacy.	ian orders dated 11/10/15, of type 2 diabetes without hysician orders directed staff sly 10 units of Lantus fly. In orders dated 10/8/16, of type 2 diabetes without hysician orders directed staff sly 4 units of Humalog g in addition to a sliding lits daily. The physician taff to Inject subcutaneously ution at bedtime. Orders dated 11/5/15, of type 2 diabetes mellitus thy. The physician orders subcutaneously 10 units of y evening with supper and less daily. The physician taff to inject subcutaneously ution every 12 hours. Orders dated 11/10/15, of type 2 diabetes mellitus. The physician orders subcutaneously ution every 12 hours. Orders dated 11/10/15, of type 2 diabetes mellitus. The physician orders subcutaneously 20 units of at bedfime and to inject 25 one time daily.	F.	431			
		stated that a maintenance					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA #DENTIFICATION NUMBER	1, ,		CONSTRUCTION	(XS) DATE COMP	SURVEY LETED
		245227	B. WING			11/	18/2015
BAYSHOF (X4) ID		B CTR ATEMENT OF DEFICIENCIES	ID	16 D	TREET ADDRESS, CITY, STATE, ZIP CODS 391 ST LOUIS AVENUE ULUTH, MN 66802 PROVIDER'S PLAN OF CORRECTION		(X5)
라유EFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	Κ	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		GOMPISTION BATE
F 44 1	director of nursing (Dr pens were reordered refrigerator was on or the medication refrige getting old. The facility policy Sto 4/14, directed medical or temperatures betw degrees F are kept in thermometer to allow On 11/12/15, at 8:15, insulin pens were obsinurse's station, near trinsulin pen had approin it, and the Lantus in approximately 130 uncontinuous observations: 45 a.m. the insulin pand staff and resident door. At 8:45 a.m. regpicked up both insulin them on the desk bed administer it after bream to normal practice to unsecured. On 11/18/15, at 12:09	11/18/15, at 10:20 a.m. the ON) stated that the Insulin and a new medication der. The DON further stated trators in the facility are rage of Medications dated tions requiring refrigeration een 36 degrees F and 46 a refrigerator with a temperature monitoring. a.m. Novolog and Lantus terved at the first floor he open door. The Novolog ximately 70 units of insulin asulin pen had lits of insulin finit. During on from 8:15 a.m. through pens remained on the desk, is were passing by the open pistered nurse (RN)-D a pens, and stated she left ause she was going to akfast. RN-D stated it was leave insulin pens		441	3. The medication refrigerators were rewith new refrigerators. The License statemps on a daily basis; the License statemps on a daily basis; the License statemps of medications which includes insulin pens. Completed 12-18-2015. 4. An audit will be conducted one (1) per week times 12 weeks to monitor it refrigerator temperatures for the properstorage of medications in the refrigeration rounds will be conducted (1) times per week times 12 weeks to monitor proper storage of medications including insulin pens by nurse manage Any negative occurrence will be address including insulin pens by nurse manage Any negative occurrence will be address including the monthly QAP1 communitor that proper storage of medications. After three months the Quentities will make a recommendative the need monitor that the temperature logs are being documented daily. Refrigerator temperature logs will be collected weekly and placed in a three binder. Logs will be kept for one year 5. The Director of Nursing/ designed weekponsible with oversight by the Administrator. Completion date of 12-31-2015	aff and frand frand frand frand frand frand frand frand france fr	
			1		†		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE IULUTH, MN 65802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Æ	(XA) COMPRETION DATE
F 441	safe, sanitary and conto help prevent the de of disease and infection. (a) Infection Control P. The facility must estat Control Program under (1) Investigates, control in the facility; (2) Decides what proceshould be applied to an (3) Maintains a record actions related to infection determines that a resignificant the spread of must isolate the reside (2) The facility must procommunicable disease from direct contact with if direct contact will train (3) The facility must rehands after each direct which hand washing is professional practice. (c) Linens Personnel must handle transport linens so as of infection.	ram designed to provide a infortable environment and velopment and transmission on. Program collish an infection er which it - cols, and prevents infections edures, such as isolation, individual resident; and a corrective ctions. If of incidents and corrective ctions. If of infection is control Program dent needs isolation to infection, the facility ent. The infected skin lesions in residents or their food, ansmit the disease, equire staff to wash their est resident contact for indicated by accepted. If of incidents and corrective ctions is indicated by accepted.	F	141			
	by:	is not met as evidenced ı, interview, and document					

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				(X3) DATE SURVEY COMPLETED	
	245227	B. WING	p <u> </u>	11/18/2015	<u> </u>
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
PRÉFIX (EACH DEFICIENCY MUST BE	SUMMARY STATEMENT OF DEFICIENCIES II (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE REGULATORY OR USC IDENTIFYING INFORMATION) TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLE DATS	тіон і
F 441 Continued From page 86 review, the facility failed to imponitor resident Infection facility falled to ensure appropand gloving practices were prefer 1 of 1 residents (R49) obsilin addition, the facility failed to precautions for 1 of 1 resident with methicillin resistant staph (MRSA) infection. The facility implement contact precaution residents (R88) diagnosed wire clostridium-difficite (G-Diff) Inferentices had the potential to residents in the facility. Findings include: In an interview on 11/17/15, a stated three residents current isolation precautions. RN-B stated three residents. RN-B stated three residents. RN-B stated the door sign (directed with the nurse before enurse what precautions they rentering a room. In the interview on 11/17/15, a stated each nursing station reresidents had infectious symptemperatures, coughing. RN-I residentprogress notes daily a morning report in order to gat related to potential infections. RN-B stated she educated stafoam out" of rooms. If a residentey are to wash their hands of the page 1/2 residented to potential infections.	entify, document s. In addition, the briate hand washing bovided during cares betwed during cares. between the contact is (R111) diagnosed bylococcus aureus between alied to s for 1 of 1 th ection. These affect all 159 It 2:47 p.m., RN-B by were currently on tated she hasn't con of precautions between all people to intering) and ask the meed to take before at 2:47 p.m., RN-B boorded what between the contact of the contact of the contact of the between the contact of the contact of the contact of the boorded what between the contact of the contact of the contact of the boorded what between the contact of the contact of the contact of the boorded what between the contact of the contact of the boorded what between the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the contact of the boorded of the	F 44			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1.	A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24 5 227	B. WING	.	<u></u> _	11	/18/2015	
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUT H, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFU TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	would talk to individual manager know. RN-B stated she had prevention and control September, teaching person could not atter packet of the presents not reviewed to determine the received this education. In an interview on 11/ Occupational Therapist we evaluating therapist we evaluating therapist we evaluation meeting with was on precautions. Of the facility, nursing way and she would in can, usually on a one-OT-D stated there we new to the facility and was a fot of uncertaint infection precautions, re-educated her staff I and glove prior to work in their room. OT-D is sani-wipes (a disinfect therapy equipment an an infectedresident is session.	s. If she saw a concern she all staff and then let their done a full infection of the class at the end of 5 or 6 classes. If a staff and, they were to review a ation and sign off. RN-B has mine if all staff have in. 17/15, at 3:38 p.m., the st (OT)-D stated the ould find out during an initial this a resident if that resident DT-D stated that the down" to other therapists, and became infectious while would inform her in some form her staff the best she by-one basis. The a lot of new therapy staff; to the profession, and there y around implementation of OT-D stated she had to wash hands, and gown king with infected residents tated therapists use ant) to wipe down all discovered when done with their therapy	i	441				
]	the room, they should	e just going in and out of put on gloves; if they are any surface in the room,						

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		DNSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		1	1601	EET ADDRESS, CITY, STATE, ZIP GODE IST LOUIS AVENUE LUTH, MN 55802	•	
(X4) ID PREFIX TAG	SUMMARY STATISHENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFX YAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DESIGIENCY)		(X5) COMPLETION DATE
F 441	train housekeeping at stated that putting a randousekeeping cart to not be done. RN-B stresident or infection-sdepartments. In an interview on 11/2 Maintenance (M)-A storemove a soiled duafter using it in a roor stated staff are not to additional rooms. In an interview on 11/2 stated she reviewed addity upon her arrival there were any infection. RN-B stated staff were on antibiotic therapy, information on reside reading a dally log wispecific information, a her or she would read R49 did not receive a during daily cares. R49 s admission redincluded failure to thricestlessness and agit annual Minimum Data indicated R49 had se required extensive as transfers, dressing, e	gloves, RN-B stated her area, so she doesn't aff on infection control. She hop back on the use in another room should ated she has not done any pecific training across other. 18/15, at 7:42 a.m., tated housekeeping staff are st mop and get it laundered in with precautions. M-A use the dust mop in. 18/15, at 8:42 a.m., RN-B all resident progress notes in the facility to determine if on control related issues, e to inform her if anyone is RN-B stated she gathered int's with infections by here nurses record resident in nurse manager would teil it in the progress notes. In the facility to determine if on control related issues, e to inform her if anyone is RN-B stated she gathered int's with infections by here nurses record resident in nurse manager would teil it in the progress notes.		441			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL- IDENTIFICATION NUMBER: A. BUILDE			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		246227	B. WING			1 41	/18/2015
	ROVIDER OR SUPPLIER			1801	EET AODRESS, CITY, STATE, ZIP CODE 1 ST LOUIS AVENUE LUTH, MN 55802		71072015
(X4) ID PREFIX TAG -	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIA OEFICIENCY)		: (XS) COMPLETION : DATE
	and NA-G were obser without using hand sa between glove change According to NA-G, Rowas saturated with uri bowel movement. NA cleaning BM off of R4! wipes. After cleaning and NA-F took off their handwashing or hand gloves. NA-F then took washed under R49's box NA-G fied up the garb incontinent product an on the floor.NA-G their room, removed her glohand-sanitizer. In an interview on 11/1 registered nurse (RN)-monitored hand washing formally the facility's undated if Control Program section 48-49) specified hand before donning and after R111 had a methicillin	of R49's cares on an unit of R49's cares on a nursing assistants (NA)-Fived to change gloves nitizer or handwashing in es. 49's incontinent product one and R49 had also had a a-Firand NA-G took turns of with disposable wet R49's perineal area, NA-G or gloves and without sanitizer, donned new of the west washefold and reasts and her armpits, age with the soiled of wet wipes and placed it obrought a stand lift into the oves and used 7/15, at 2:47 p.m., B stated that she hasn't no formally. She did do a possible to be completed ar removing gloves. resistant staphylococcus on and the facility did not	F	141			
	precautions.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(x2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SVRVRY COMPLETED		
		245227	B. WING			11/	18/2015	
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 66802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID FROVIDER'S PLAN OF CORRECTION PREFIX (GACH DORRECTIVE ACTION SHOULD BE TAG GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 441	included methicillin reaureus infection, peri aneurysm of artery of admission minimum of 8/31/15, indicated he had surgical wounds. An 11/15/15 progress R111's left heel. The bilister had popped withe area was cleane applied a non-stick prophysician orders for y clean the wound, applied a hon-stick prophysician orders for y clean the wound, applied a hon-stick prophysician orders for y clean the wound, applied a hon-stick prophysician orders for y clean the wound, applied a hon-stick prophysician orders for y clean the wound, applied and head and an addition the IAR in medication sulfameth antibiotic) for 14 days. In an observation on R111's room had an outside the room, but directing staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering and the prophysical staff or visite before entering. An open sulfament in the prophysical staff or visite before entering and the prophysical staff or visite before entering and the prophysical staff or visite before entering and the prophysical staff or visite before entering and the prophysical staff or visite before entering and the prophysical staff or visite before entering and the prophysical staff or visite before entering and the prophysical staff or visite before e	ord identified diagnoses that esistant staphylococcus pheral vascular disease, and a lower extremity. R111's data set (MDS), dated was cognitively intact and anote indicated a blister to note continued that the thyellowlsh/red drainage, dwith wound cleaner and ad and wrapped. 11/16/15 wound care directed staff to oly telfa and tegaderm eragency Referral Form identified MRSA as a high on the first page of the form. dicated R11 was on a new exazole-trimethoprim (and after discharge. 11/15/15, at 7:04 a.m., infection control station in sign on the door ors to check with the nurse observation on 11/17/15, at nere was still no sign on lad a sign put on R11's door	F	441				

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11.	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245227	B, WING			11/18/2015		
NAME OF P	ROVEDER OR SUPPLIER	242221		STREET ADDRESS, CITY, STATE,	L ZIP CODE	11/10/2010		
BAYSHO	RE RESIDENCE & REHA	B CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 441	Continued From page	91	F	441				
	stated CDC guideline which isolation precaudid not know if all thresheen cultured and if no why they weren't. RN check." No further clark-B also stated any precautions, they don In an interview on 11/stated R111 had return 8/25/15. RN-B stated R111's leg wound had resident on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact pr R111 was not on contact precautions only durin R88 had a Clostridium infection, and the facili appropriate infection of Findings include: The Center for Diseas for health care facilities when caring for reside infection: Isolate patie immediately. Wear glot treating patients with 6 visits. Hand sanitizer of although hand washin not be sufficient alone gloves. Clean room sudaily basis while treating and upon patient discissupplement cleaning of Supplement cleaning supplement	arification was provided. Inurse can implement It have to wait for orders 18/15, at 8:42 a.m., RN-B med from the hospital on as soon as she found out If infection she placed the recautions. RN-B confirmed recautions from In the hospital, until RN-B rons on 9/1/15. RN-B stated entation was for staff to use reg wound cares. In difficile (C. difficile) rity did not implement control precautions. If Control (CDC) guidelines as directed the following rents with a C. Difficile rows and gowns when C. difficile, even during short does not kill C. difficile, and g works better, it still may thus the importance of refaces thoroughly on a ring a patient with C. difficile rearge or transfer.						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1.	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1601 ST LOUIS AVENUE DULUTH, MN 55802	Œ		
(X4) ID PREF;X TAG	(EACH DEFICIENC)	4) EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FURE ISC IDENTIFYING INFORMATION)	IC PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE		(X5) COMPLETION DAT≌
F 441	Included enterocolitis (a spore-forming bact and irritation of the lar inflammation, known diarrhea, fever, and a R88's admission Mini indicated R88 was co extensive assistance was frequently incont results on 9/24/15, ar the presence of C. dif On 11/8/15, at 3:42 p was interviewed, and precautions due to a stated staff were not i prior to entering R88's coming into direct cor verified R88 had toos On 11/10/15, at 7:34 (NA)-L was observed was a yellow sign on contact precautions, v Visitors see nurse be door was an isolation masks and sanitizing coffeepot in her hand entered R88's room. I hands, or put on a go coffeepot on a bedsic Housekeeper (H)-A ti did not wash her hand had a dry mop, and p floor. NA-L proceeded left the room without i placed the dry mop o NA-L teft the room wit	ord identified diagnoses that due to Clostridium difficile eria that can cause swelling rge intestine, or colon. This as colitis, can cause bdominal cramps). mum Data Set (MDS) gnitively intact, required of two staff for toileting, and inent of bowel. Laboratory id 10/13/15, both identified ficile in R88's stool. m. registered nurse (RN)-C stated R22 was on isolation C. difficile infection. RN-C required to gown and gloves room, unless they were stact with R88's stool. RN-C estools that day. a.m. nursing assistant entering R88's room. There R88's door; it directed "stop wash hands, gown, glove, fore entering". Outside the cart with gowns, gloves, wipes. NA-L had a s, knocked on the door and NA-L did not wash her wn or gloves. NA-L put the	F	141			

Facility IC; 00588

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CEMA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING		- Hanned	11	/18/2015
NAME OF PROVIDER OR BAYSHORE RESIDE		B CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
'	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	DED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE	
the room, did not go room, becand made washed? was on hinterviewed when going alcohol by 7:57 a.m., on her he supposed cart, and not done On 11/10 alde (TM/did not has thermome stated if the clean there is supposed to wash the clean there is supposed cart, and not done On 11/10 alde (TM/did not has thermome stated if the clean there is supposed if the clean there is supposed if the clean there is supposed if the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean the clean there is supposed in the clean the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in the clean there is supposed in th	own or glove cause she jue his bed. N/her hands wher hands wher way to do ed and stateing into R88's ased sanitized. H-A was obsusekeeping if to take the replace it will this yet. (15, at 10:05 A)-E was into a dedicate or blood hese were used of R88's door, helr hands welcohol base and leaving the pect nursing the pect nursing the pect nursing the pect nursing the whether or digloves, or then entering facility did not retering fac	nterviewed and stated she when she went Into R88's st brought him fresh coffee, A-L stated she had not be leaving the room, she that now. H-A was dishe did not gown or glove is room, but she did use an er when she left the room. At served with the dry mop still cart. H-A stated she was soiled dry mop off her her that a clean one, but she had a.m. trained medication prviowed, and stated R88 ted stethoscope, pressure cuff. TMA-A sed on R88, staff should	F	441			

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STATEMENT OF DEFICIENCES (X1) PROVIDER/SUPPLIER/CLSA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING			COMPLETED				
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	AB CTR	STREET ADDRESS, CRTY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID 유REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC'I'ON (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERINGED TO THE APPROPRI DEFICIENCY)	}E	(K5) COMPLETION DATE
F 441	do it soon. RN-B statt blood pressure cuff, sthermometer on R88, equipment with a san educated them on it y. In an observation on certifled occupational was observed enterinclipboard. The COT/Froom entry, but did a COTA did not touch a handle to close the did not wash or sanitithe room. The COT/Fithe clipboards to use On 11/12/15, at 7:14 and stated the sanitizer cart outside of R88's. The facility policy and Difficite undated, directive in remove When possible, non-should be declicated. Based on interview a facility failed to ensure screening, including a test (TST) (a skin test individual had been einfected with TB), and screening was complipator to providing care	and the facility will start to ed if staff were using the stethoscope and they should be cleaning the sitizing wipe, but she hasn't yet. 11/10/15, at 10:29 a.m., I therapist assistant (COTA) ag R88's room with a A did not gown or glove upon pply hand sanitizer. The anything, but did use the door oor upon exit. The COTA ize her hands after exiting a stated that she would take in other rooms. a.m. RN-B was interviewed, ting wipes on the isolation room did not kill spores. I procedure on Clostridium rected staff to wash hands alcohol gels or handrubs are ving or killing the spores a critical care equipment to the patient with C. difficile, and document review, the re Tuberculosis (TB) a two-step tuberculin skin t to assist in identifying if an exposed to TB or was d a TB baseline symptom leted upon employment and leted upon employment and letes for 9 of 10 direct care litential to affect all 159	F	41			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X8) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X8) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTI			(X3) DATE SURVEY COMPLETED			
		245227	B. WING_		11/18/2	015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CRY, STATE, ZIP CO 1801 ST LOUIS AVENUE DULUTH, MN 55802		
(X€) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO.	(X6) MPLCTION DATE
F 441	Continued From page	96	F4	141		
	Health-Care Setting, health care workers in screening upon hire. an assessment of the TB, and any current TST (tuberculin skin togamma release asset)	for Preventing the obacterium Tuberculosis in 2005 (MMWR) directed all nust receive a baseline TB. The screening must include employees risk factors for TB symptoms. A two-step est) or a single interferon y (IGRA), or a chest x-ray ained in the employee.				
	and employee list ind * NA-N was hired 3/1 tuberculin skin test TS	Ž.				
	5/30/13. The second- administered late. NA-O was hired 10, was administered on was administered 6/1	step TST was /27/14. The first-step TST 6/3/15 and the second TST 0/15. The baseline				
	The screening was not NA-G was hired 10/1 was administered on 10 receive a second-step screening was complet * NA-M was hired on TST was administered step TST had not bee baseline symptom scr 10/26/15. * NA-P was hired on	TST. The baseline symptom ed on 10/15/15. 10/26/15. The first-step d on 10/26/15. The second-				
	had not been administe	•				ĺ

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245227	B. WING_		11.	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		•	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 56802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMONT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTEYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(AS) COMPLECON DATE
F 441	completed on 5/17/11 * NA-Q was hired on TST was administered second-step was administered the TS screening was time of hire. * NA-R was hired on TST was administered another one second-step TST was administration, the TS after administration. T screening was completed a TST on 9/3 at facility. The first-steen 10/26/15. The bas was completed on 10 * NA-U date of hire was were no TST's or bas done for this date. The step TST results; one other dated 12/2/14. / screening was completed a TST on pilother dated 12/2/14. / screening was completed screening was completed to 10/24/14. was administered 10/24/14. was administered 10/24/14. was administered 10/24/14. registered nurse (RN)-have a negative TST bresidents, and the section.	symptom screening was 12/26/12. The first-step d on 10/24/14. The iinistered on 12/17/14. In screening was undated. In not completed at the 10/14/13. The first-step d on 10/11/13. There was the second-step. NA-R Istep TST on 6/1/15. The Iread 5 days after IT is to be read 48-72 hours the baseline symptom Ited on 10/14/13 and 10/26/15. NA-T had 21/15, prior to employment the TST was administered the symptom screening IZE/15. Ites listed as 7/23/15. There the symptom screening IZE/15. Ites listed as 7/23/15. There were 2 previous one- dated 11/4/10, and the IX baseline symptom ted with each TST. IX. A one-step TST was Another one-step TST IX. A baseline symptom and with each TST. IX. A baseline symptom and with each TST. IX. A stated the employee must refore they can work with IX. B stated the given IX. RN-B verified some	F4	1. No residents were affected by alleged deficient practice. 2. All residents have the potent be affected by the alleged depractice. 3. Staff will be in-serviced on the Falinfection control Policies and Proceed which includes the implementation of isolation precautions and ensuring colored washing. The Staff Developmed Infection Control Coordinator will implement infection control precautions and ensuring colored guidelines in a timely manner, upon admission or readmission, or we current resident if precautions are wall. Observation rounds will be conducted times per week times 12 weeks to monitor the facility's infection programmelude isolation precautions and conhand washing. Any negative occurrence be addressed immediately.	cility's ures, f mplete at mons per And ith any granted.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		SURVEY
		245227	8 WING			11	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	TREET ADDRESS, CRTY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMIENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION INATE
	TSTs repeated becau their second-step TST stated the employee is them when they need have the first-step TST second-step TST adm followed up with huma. The undated facility per Tuberculosis Control fapplicants for employing a two-step TST tuberculosis, 483.70(h)	se they were late having "administered. RN-B s given a form that directs to come back either to F read, or have the ninistered. RN-B stated she an resources. clicy and procedure for Plan directed all qualified ment would be screened or a blood test for	F4	165	The results of the observation rounds be presented to the monthly QAP1 committee to review and make recommendations. After three months QAPI committee will make a recommendation as to the need to conto monitor the facility wide infection control program. 5. The Director of Nursing/designee with esponsible with oversight by the Administrator. Completion date of 12-31-2015	the tinuc	
	sanitary, and comfortaresidents, staff and the This REQUIREMENT by: Based on observation review, the facility fails were well maintained if (rooms 121, 143, 151, addition, the facility fails was properly maintain (R129) reviewed for elforthings include: On 11/17/15, at 2:59 prompleted with the dim (DM)-B and the enviro	able environment for a public. Is not met as evidenced In, interview and document and to ensure resident rooms for 8 of 15 resident rooms 159, 160, 210, 212, 267) In alled to ensure a wheelchair and for 1 of 1 residents evironmental concerns.			 Resident room's il 121,143,151,159,160,210,212,257 and wheelchair in room 129 were repaired, painted and or fixed to reflect a more homelike environment. All resident rooms have the potential not having a homelike environment. 		

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3 IDENTIFICATION NUMBER: A, BUILDING			3) DATE SURVEY COMPLETED			
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	в стр	:	16	TREET ADDRESS, CSTY, STATE, ZIP CODE SOI ST LOUIS AVENUE ULUTH, MN 55892		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING IMPORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DESIGNERCY)		(X5) CAMPLETION DATE
F 465	confirmed by both DN Room (RM) 121 had is sharp edges in the virithe main door. RM 143's bathroom him of the toilet. The collet was cracked, perfour dime sized chips bathroom. The built in exposing the particlet corner. RM 151's caulking at cracked, peeled and castrong urine smell. RM 159's caulking at cracked, peeled and castrong urine smell. RM 160's bathroom sporcelain. RM 210's bathroom flaround the base of the the corners behind the There were also dark floor near the toilet. RM 212's private roor	In swere identified and II-B and ED-A. wo 2 inch (in) gouges with anyl doorknob guard behind and multiple scratches on the aulking at the base of the eled and dirty. There were in the tiled wall in the closet had 6 in, long gash loard on the bottom right the base of the toilet was firty. The bathroom also had the base of the toilet was firty. Ink has three cracks in the cor had yellow staining to toilet. Dirt was observed in the toilet and below the sink, splatters on the wall and in lacked a privacy curtain.	ř.	465	3. The facility utilizes the Direct Supping Tels system, which allows all depart to alert the Maintenance department of resident rooms, resident environment the resident's equipment that need repattention. An audit of ten (10) resident rooms will be conducted each week for weeks to assure the rooms are maintain reflect a more homelike environment, item or items needing repair, painting fixing will be addressed immediately, system will be ongoing throughout the The results of the audits will be present the monthly QAPI committed monthly three (3) and quarterly thereafter for ony car to assure a system of maintaining resident rooms in a homelike environment.	tments f and or air or d or 12 ned to Any or This e year, ited to / for ite ; the	

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

Facility ID: 00589

NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB OTR CV4) 10 CV4) 10 EGACH DEPLICATIVE VISIT SELEMENT OF PERCICIONGES FOR MANAPY STATEMENT OF PERCICIONGES EGACH DEPLICATIVE VISIT SELEMENT OF PERCICIONGES FOR MANAPY STATEMENT OF PERCICIONGES FOR MANAPY STATEMENT OF PERCICIONGES EGACH DEPLICATIVE VISIT SELEMENT OF PERCICIONGES FOR MANAPY STATEMENT OF PERCICIONGES FROM THOUGH AND SELEMENT VISIT SELEMENT OF PERCICIONGES FROM THE PROPERTY OF THE APPROPRIATE CONSISTENCE TO THE APPROPRIATE CONSISTENCE OF THE APPROPRIATE C		MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
BAYSHORE RESIDENCE & REHAB CTR CA910 CA910 PRETRY TAG SUMMARY STATEMENT OF PERCEDENCES (EACH OFFICIENCY MUST be refered by TYLL RESULATORY OR USE DIDNIFFINIS REGIDENCY RESULATORY OR USE DIDNIFFINIS REGIDENCY TAG FACTOR CHECKING AND THE REPORT OR USE DIDNIFFINIS REGIDENCY TAG FACTOR CHECKING AND THE REPORT OF THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO THE ADMINISTRATION OF THE ADMIN			245227	B. WENG			11	/18/2015
FASS FASS Continued From page 99 R129's wheelchair's right-sided arm support was worn through the top layer exposing the cushion. After the four on 11/17/15, at 3:33 p.m. DM-B stated the has not been currently performing routine maintenance rounds in the resident rooms since the ED-A stated working in the facility monthly, however his checklist did not include maintenance specific tasks to lock for and document for follow up. DM-B stated the facility does not have any from maintenance policles aside from housekeeping. The facility policy "Resident Restroom Cleaning" directed housekeepers to sweep, dust and more the entire floor, moving any items that may be in the bathroom. The facility did not provide a policy on maintainence of resident's comp, resident's equipment F 494 483.75(e)(2)(3) NURSE AIDE WORK > 4 MO - SSSE TRAINING/COMPETENCY A facility must not use any Individual working in the facility as a nurse eide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, approved by the State as meeting the requirements of §\$483.154.63 of this part; or that individual has been deemed or determined competent as provided in §483.150(6) and (6). A facility must not use on a temporary, per diem,			BCTR		16	601 ST LOUIS AVENUE		
R129's wheelchair's right-sided arm support was worn through the top layer exposing the cushion. After the tour on 14/17/15, at 3:33 p.m. DM-B stated he has not been currently performing routine maintenance rounds in the resident proms since the ED-A started working in the facility. ED-A stated that he rounds every room in the facility monthly, however his checklist did not include maintenance specific tasks to look for and document for follow up. DM-B stated the facility does not have any room maintenance policles aside from housekeeping. The facility polloy "Resident Restroom Cleaning" directed housekeepers to sweep, dust and mop the entire floor, moving any items that may be in the bathroom. The facility did not provide a polley on maintainence of resident's rooms, resident's environment or resident's equipment. F 494 483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any Individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §4:483.154 of this part; or that individual has been deemed or determined competency and the program approve	PRÉFIX	(EAGH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
leased, or any basis other than a permanent employee any Individual who does not meet the	F 494 SS=F	R129's wheelchair's ri worn through the top I After the tour on 11/12 stated he has not bee routine maintenance r since the ED-A started ED-A stated that he rotacility monthly, hower include maintenance s document for follow up does not have any rocaside from housekeep. The facility pollcy "Redirected housekeeper the entire floor, moving the bathroom. The facon maintainence of redenvironment or reside 483.75(e)(2)-(3) NURS TRAINING/COMPETE A facility must not use the facility as a nurse amonths, on a full-time is competent to provide related services; and the completed a training a program, or a compete approved by the State requirements of §§483 or that individual has be competent as provided. A facility must not use leased, or any basis of	ght-sided arm support was layer exposing the cushion. 7/15, at 3;33 p.m. DM-B in currently performing ounds in the resident rooms divorking in the facility. Sunds every room in the ver his checklist did not specific tasks to look for and p. DM-B stated the facility or maintenance policles bing. sident Restroom Cleaning stock to sweep, dust and moping any items that may be in sility did not provide a policy sident's rooms, resident's not's equipment. SE AIDE WORK > 4 MO - SNCY any Individual working in aide for more than 4 basis, unless that individual enursing and nursing hat individual has and competency evaluation ency evaluation program as meeting the 3.151-483.154 of this part; seen deemed or determined in §483.150(a) and (b). on a temporary, per diem, ther than a permanent			with oversight by the Administrator w responsible. Completion date of 12-31-2015. 1. No residents were affected by the all deficient practice. 2. All of the nursing assistant evaluation have been completed. Completion date	ill be leged	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY IPLETED
		Z45227	g. WING			11	/18/2015
	ROVIDER OR SUPPLIER		1	16	REET ADDRESS, CITY, STATE. ZIP CODE 101 ST LOUIS AVENUE ULUTH, MM 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC (DENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PEAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 494	this section. Nurse aides do not in furnish services to reassistants as defined. This REQUIREMENT by: Based on interview facility failed to ensure were completed for a past 12 months. This all 159 residents restricted in the following employees performance reviews months: Nursing ass N, NA-Z, NA-R, NA-During an interview of the human resource NA performance reviews months: The HRD-were done in 2013, Inches to the HRD-I verified not done in 2014, and the transmitted in the transmitted in the HRD-I verified not done in 2014, and the transmitted in the transm	graphs (e)(2)(i) and (ii) of include those individuals who esidents only as paid feeding it in §488,301 of this chapter. This not met as evidenced and document review the reperformance reviews all nursing assistants in the shad the potential to affect liding in the facility. Dyee files indicated the did not have a completed in the past 12 sistant (NA)-D, NA-Q, NA-C, NA-V, and NA-W. In 11/18/15, at 9:04 a.m. as director (HRD)-I stated no lews were completed in the last reviews by the previous company. In 11/18/15, at 12:06 p.m. or performance reviews were not the evaluation dates found as were most likely accurate.	F	494	3. The Administrator reviewed the forequirements and the Standards of the of Minnesota with the Director of Nurand the Director of Human Resources regarding the requirement of nursing assistants having an annual evaluation the beginning of each month, IRR will out an evaluation form and a list of the CNA anniversary dates for that month will be the expectations that the Unit Managers complete the evaluation by end of that month. 4. An audit will be completed month three (3) months, then quarterly for or year to assure evaluations are completed to the month QAPI committee to monitor the system annual evaluations are being completed.	State ring n, At send e n. It the the y for he ted per ses y m of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GUA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
		245227	B. WING			11	/18/2015
NAME OF PI	ROVIDER OR SUPPLIER	atvaar		81	REET AUDRESS, CITY, STATE, ZIP CODE		10,2010
- 4./4/4			1601 ST LOUIS AVENUE				
BAYSHOR	RE RESIDENCE & REHA	B CTR		D	ULUTH, MN 55802		
(X4) ID		ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAO	'	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFID YAG	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION DATE
:					5. The Director of Nursing /designed a	nd	
F 494	Continued From page	101	F-	494	the Director of Human Resources/ desi	ignee	
					will be responsible with oversight by t	ne	
		e for performance reviews			Administrator.		
E //05	was not provided.	AIDE WORK < 4 MO -		40=	Completion date of 12-31-2015,		
	TRAINING/COMPETS		Γ.	495	Completion age of 12-01-2015		
00-1	TOMINATOOOMI ETE	1401	1				
		any individual who has	1				
		onths as a nurse aide in that	1				
	facility unless the indiv employee in a State-a				1. No residents were affected by the all	leged	
	competency evaluatio				deficient practice.		
		ence through satisfactory			2. No residents were affected by the al	leged	i
		e-approved nurse aide			delicient practice.		
		icy evaluation program or					
		n program; or has been d competent as provided in					
	§§483.150(a) and (b),	2 competent as pravided in	İ	Į			
	50 (-),(-),			ĺ			
		is not met as evidenced					
	by: Rased on interview at	nd document review, the					
		new employees receive					
	appropriate orientation						
	providing direct care to	residents. This has the]			
		59 residents residing in the	1			1	İ
	facility.		Ì	Į		Ì	
	Findings include:						
		training Indicated nursing					
		AA, and NA-G had not				ļ	i
	received new employe						
	employee list indicated 10/26/15, and the sche	nA-M was nired on dule indicated she had					
		zares. NA-AA was hired on			-		
		ile Indicated he has been		- 1			
	providing direct cares.						
			1	[

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPE/ER/CLIA 3DENTSFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETIED
		245227	B.WING_		and a first transfer of the second se	11/	18/2015
	ROVIDER DR SUPPLIER RE RESIDENCE & REHA	B CTR		16	REET ADORESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 495	been providing direct 10/26/15, and the sch been providing direct During an interview or registered nurse (RN NA-AA,NA-G, and N/employee orientation attend 12/9/15. RN-B receive some information number of some information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information of the second sure what information orientation. A facility policy and policy and policy and interview of the second sure what information.	nedule indicated she had cares. NA-T was hired on hedule indicated he had cares. In 11/18/15, at 8:30 a.m.)-B verified NA-M, A-T had not attended new and were scheduled to stated new employees ation in their packet from R) when they start. RN-B formation they receive from the had not educated the abuse prevention, trights. In 11/18/15, at 12:08 p.m. the stated new employees regarding payroll, job conduct, and resident rights, employment information. The ontreceive Information on the receive Information the hiring NAs faster than is held. Orientation Training indicated infection prevention and a were to be included in the receive for new employee.	F4	95	3. Employees have received the approprientation and training prior to provid direct care to residents All new staff received the appropriate orientation properties and to care for staff. Complete 30-2015 4. An audit of personnel files will be conducted one (1) time per week time weeks, then monthly for one year to nothat all new staff have had the appropriorientation prior to providing direct of assure a system of assuring new employers the appropriate orientation prior to providing direct care. 5. The Director of Staff Development /designed will be responsible with overfrom the Administrator. Completion date of 12-31-2015.	have have lier to ed 12- s 12 conitor riate cre.	
F 496 SS=F	orlentation was not p 483.75(e)(5)-(7) NUR VERIFICATION, RET	SE AIDE REGISTRY	F 4	96	No residents were affected by the a deficient practice.	lleged	

Event lb: GY0H11

	OF BEHICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:		ING		(×	3) DATE SURVEY COMPLETED
		245227	B. WING				11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REH		1	1601 ST	ADDRESS, CITY, STATE, ZIP CODE LOUIS AVENUE H, MN 55802	1_	11110/2414
(X4) ID PREFIX TAG	(SACH ORFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	ID PREFI; TAG	(PROWDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS)
F 498	aide, a facility must in that the individual has requirements unless employee in a training evaluation program a individual can prove successfully complete competency evaluation program a has not yet been inclinated facilities must follow individual actually be Before allowing an imaide, a facility must a Stafe registry establic (2)(A) or 1919(e)(2)(believes will include in training and competing and competing and competing individual provided in services for monetangind individual must competency evaluation. This REQUIREMENT by: Based on Interview a facility failed to ensure	individual to serve as a nurse receive registry verification as met competency evaluation the individual is a full-time ag and competency approved by the State; or the that he or she has recently ted a training and ion program or competency approved by the State and luded in the registry. If up to ensure that such an ecomes registered. Individual to serve as a nurse seek information from every shed under sections 1819(e) A) of the Act the facility information on the individual. It's most recent completion of othercy evaluation program, attinuous period of 24 during none of which the ursing or nursing-related by compensation, the other a new training and on program or a new	F	496			
ĺ	-	are to residents. This had all 159 residents residing in					1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 801 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFUX TAG	(EACH DEFICIENC	ATRIARNT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		(X5) COMPLETION DAT≐
F 496	working in the facility registry. Nursing ass included on the list provate checked with the A review of the schedworking with resident with another NA until schedule independent days between 10/31// During an interview of director of nursing (Dhow often the NA regional processing and the nursing certification had lapsed been working as a nutil HRD-I verified a regist to employment for NA During an interview of DON verified she was registration/certification and not been under of the time. During an interview of NA-M verified she had not been under of the time.	a list of all nursing assistants and who were on the state istant (NA)-M was not ovided by the facility that registry. Jules, indicated NA-M began is on 11/28/15, and worked 10/31/15. NA-M was on the try one to two shifts 14 of 19 15, and 11/18/15. In 11/18/15, at 7:41 a.m. the ON) stated she was not sure listry is checked. In 11/18/15, at 12:16 p.m. the ctor (HRD)-J verified NA-M grassistant registry and her and HRD-I stated NA-M had ursing assistant in the facility. After the check was not done prior and the sunaware that NA-M's an was not current until that ified NA-M had been assistant in the facility and irect supervision 100% of an 11/18/15, at 1:48 p.m. did been working as a nursing yand had provided cares to	F	496	 2. All residents have the potential to be affected by the practice. 3. NA-M is current with her certificat. All nursing assistant certifications have been verified as current. 4. An audit will be conducted each me for three (3) months and then quarterly one year to monitor that all nursing as certifications are current. The results audits will be presented to the monthly QAPI committee to assure that no nurses is that is allowed to provide direct of a resident without a current certificate. 	ion. ye onth y for sistant of the y rsing care to	

	OF DEFICIENCIAS CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1, ,		CONSTRUCTION		SURVEY PLETED
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER			16	REET ADDRESS, CITY, STATE, ZIP CODE		10,2010
			<u>l</u>	D	ULUTH, MN 65802		,
(X4) ID PREFIX TAG	(BACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) CGMPLETION DATE
F 496	Continued From page unsupervised.	105	F	196	 The Director of Human resources/designee will be responsible oversight from the Administrator. 	with	
F 498		-	į F4	198	Completion date of 12-31-2015.		
	COMPETENCY/CARI		'				
	to demonstrate competechniques necessary needs, as identified the	to care for residents!			 No residents were affected by the al- deficient practice. 	leged	
	by: Based on interview a facility failed to ensure annual education and education to maintain	d the potential to affect all					
	Findings Include:						
	nursing assistants (NA been hired in the past were scheduled to recorientation. The rema employed at the facility months, and had received training since 1/15: * NA-W had received a prevention/reporting a	ining NAs had been y for greater than 12 ived the following hours of 4.5 hours, including abuse nd general training. No evention or control, resident					

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3	DATE SURVEY COMPLETED
	•	245227	B, WNG			11/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		·	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REPERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 498	prevention/reporting a dementia, infection president rights, or prive mandatory training wat NA-Z had received include mandatory training, prevention/reporting, prevention or control, training, or other man * NA-C had received 9 prevention/reporting, indementia, resident right other mandatory training wat received prevention or control, training, or other man received. * NA-R had received include mandatory training, or other man * NA-P had received include mandatory training, or other man * NA-P had received abuse prevention/reporting, prevention prevention or control, training, or other man * NA-P had received abuse prevention/repinfection prevention or other man abuse prevention/repinfection prevention or other mandatory training, or other mandatory training, or other mandatory training, or other mandatory training, or other mandatory training, or other mandatory training, or other mandatory training or other	7.5 hours, including abuse and general training. No revention or control, racy training, or other as received. 1.0 hours, did not alining, such as abuse dementia, infection resident rights, privacy datory training. 5 hours, including abuse affection prevention. No assert or privacy training, or any was received. 1.5 hours, including abuse affection prevention, infection resident rights, privacy adatory training was 5.0 hours, did not alining such as abuse dementia, infection resident rights, privacy adatory training. 8.5 hours, Including orting. No dementia, or control, resident rights, her mandatory training 6.5 hours, Including orting. No dementia, or control, resident rights, her mandatory training 3.0 hours, did not alining such as, abuse	F	498		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER;	1		CONSTRUCTION		SURVEY PLETED
		245227	B. WING			11:	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	8 CTR	ID.	16	TREE I AUDRESS, CIFY, STATE, ZIP CODE 901 ST LOUIS AVENUE ULUTH, IMN 55802		["-
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI GROSS-REFERENCED TO THE APPROPRIA PEFICIENCY)		(X5) COMPLETION DATE
F 498	prevention/reporting a control. No demential training, or other man received. During an interview or director of nursing (Do training will be starting is hard to expect the a they are at work, so withey will be able to do for that. During an interview or registered nurse (RN) above had not receive training since at least of the previous training the NAs were to receive training since at least of the previous training the NAs were to receive and had been offered throughout the training unable to locate. RN-been offered over 22 land had been offered throughout the year to RN-B stated she provious training. RN-B verified up on the status of each training. RN-B verified up on the status for each training. RN-B verified up on the status for each training, they had to do the employee had dor been included in the had	datory training. 5.5 hours, including abuse and infection prevention and resident rights, privacy datory training was 1.1/18/15, at 7:41 a.m. the DN) stated a new electronic groon. The DON stated it staff to attend training when with the electronic training. It at home and will get paid 1.1/18/15, at 8:30 a.m. B verified the staff listed at 12 hours of mandatory 1/15. RN-B was unaware greceived. RN-B stated we 12 hours of training sure of the mandatory, but had a list that she was B stated the NAs have hours of education this year, several opportunities obtain their 12 hours. Ided the nurse managers of employee and their did that she had not followed ach employee. RN-B stated and was offered in March, and an educational packet of the employee missed the or the make-up packet. If the the packet, it would have ours reported. RN-B stated to electronic training and	F	498	 All residents have the potential to be affected by the alleged deficient praction. Nursing assistants have received the hour mandatory training. An audit o will be completed each for three (3) months then quarterly for year to assure any nursing assistant requiring their 12 hour of mandatory education in a twelve month period of will have completed their mandatory training/education. 	ice. eir 12 month r one	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A, BUILDING			SURVEY PLETED
		245227	B. WING			11/	18/2015
	RDVIDER OR SUPPLIER	8 CTR		16	REET ADDRESS, CITY, STATE, ZIP CODE D1 ST LOUIS AVENUE ULUTH, MN 56802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFIGIENCY)		(X8) COMPLETION DATE
F 498	Continued From page A facility policy for sta	108 ff education was requested	F	498	 The Director of Staff Development/designee will be respons with oversight by the Administrator. 	ible	
i	but not provided. 483.75(h) OUTSIDE F RESOURCES-ARRA	PROFESSIONAL	F	500	Completion date of 12-31-2015.		
V	If the facility does not professional person to to be provided by the have that service furn person or agency out arrangement describe Act or an agreement (2) of this section.	employ a qualified of furnish a specific service facility, the facility must lished to residents by a side the facility under an ed in section 1861(w) of the described in paragraph (h)			 No residents were affected by the aldeficient practice. All residents may have the potential affected by the practice. 		
	the Act or agreements furnished by outside r writing that the facility obtaining services tha standards and princip professionals providing	nts as described in section 1861(w) of greements pertaining to services outside resources must specify in the facility assumes responsibility for services that meet professional and principles that apply to is providing services in such a facility; eliness of the services.			3. An updated contract for Therapy we obtained by 12-1-2015	ns	
	by: Based on interview a facility failed to ensure therapy, occupational therapy was current.	Is not met as evidenced nd document review, the the contract with physical therapy, and speech This had the potential to s residing in the facility.			 All contracts will be reviewed quart at the QAPI committee to monitor that contracts remain timely and updated. (going. 	;	
	therapy, occupational	Agreement for physical therapy, and speech d 7/1/13, was between the					
	merapy services date	d 111/10, was between tite	1				

Facility ID: 00589

PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE	E SURVEY PLETED
BAYSHORE RESIDENCE & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 500 Continued From page 109 previous owner of the facility and the therapy provider. F 500 Completed 12-31-2015.	/18/2015
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 500 Continued From page 109 previous owner of the facility and the therapy provider. F 500 Completed 12-31-2015.	
F 500 Continued From page 109 previous owner of the facility and the therapy provider. F 500 responsible, Completed 12-31-2015.	(XS) COMPLETION DATE
the administrator verified the contract would have to be updated. The administrator stated he would expect contracts would have been updated with the change in ownership. The administrator stated there had been no break in service for the residents residing in the facility. A policy for contract renewals was not provided. F 502 SS=C The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on Interview and document review the facility failed to ensure the contract for laboratory services was current. This had the potential to affect all 159 residents residing in the facility. Findings include: The facility did not have a signed contract for laboratory services to be provided for the facility. The letter of agreement dated 12/23/13, for services to be provided for the facility. The letter of agreement was signed by the laboratory provider only, and not by the facility. During an interview on 11/18/15, at 12:51 p.m. the administrator verified the confract would have	

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	OF DEFICIENCIES CORRECTION						
		245227	e. WING_			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA	B CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF PEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMFLETION DATE
F 502	expect contracts wou the change in owners stated there had beer residents residing in t A policy for contract r	dministrator stated he would ld have been updated with hlp. The administrator n no break in service for the	Fŧ	502	 4. The Laboratory contract will be reviguarterly in the QAPI committee to me the date of the contract. On going. 5. The Administrator/ designee will be responsible. Completion date of 12-31-2015. 	onitor	
	other diagnostic servi	OSTIC SVCS ide or obtain radiology and ces to meet the needs of its y is responsible for the	F.5	808	 No residents were affected by the a deficient practice. All residents have the potential to b affected by the alleged deficient pract 	e	
	by: Based on interview a facility failed to ensur services were current affect all 159 resident Findings include: The Imaging and Rac dated 12/2/09, was b the facility and the rac During an interview o the administrator veri to be updated. The a expect contracts wou the change in owners	n 11/18/15, at 12:51 p.m. fied the contract would have idministrator stated he would ld have been updated with hip. The administrator n no break in service for the			 3. The Radiology contract has made e 4. The radiology contract will be revie quarterly at the QAPI committee to m the date of the contract. On going. 5. The Administrator/designee will be responsible. Completion date of 12-31-2015. 	ewed onitor	

Facility ID: 00689

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	1 ' '	E SURVEY PLETED
		245227	Ð. WING	,		11	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE . 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(SACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH GORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFIGIENCY)		(X5) · COMPRETION STATE
F 514	483.75(i)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practic accurately documente systematically organiz The clinical record mulinformation to identify resident's assessment services provided; the preadmission screenin and progress notes. This REQUIREMENT by: Based on interview a failed to ensure accuracion completed for 5 of 5 re R76, R109) reviewed reviews. Findings include: R15's quarterly Minimi 9/11/15, included diag and dementia. The MI taking insulin, diuretics antianxiety medication R15's had an admission pharmacy consultant of the second	tain clinical records on each ewith accepted professional es that are complete; ed; readily accessible; and red. Ist contain sufficient the resident; a record of the ts; the plan of care and results of anying conducted by the State; is not met as evidenced and record review, the facility ate medical records were esidents (R15, R38, R61, for monthly pharmacist and page 15 indicated R15 had been a antipsychotic and		508 514	 No residents were affected by the affected practice. All residents have the potential to be affected by the practice. The pharmacy consultant reports winow be individualized and filed in the residents chart. An audit will be completed each me for three (3) months to monitor the pharmacy consultant reports /recommendations have been filed in the resident's chart. These audits will be presented to the monthly QAPI committee will make a recommendation as to the need to contate to monitor that the Consultant pharmac reports are being filed in the residents' chart. The Director of Nursing/designee were sponsible with oversight from the Administrator. Completion date of 12-31-2015. 	e ill ittee he iinne	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIFIR/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION		SURVEY PLETED
		246227	B. WING			11/	/18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA			16	REET ADDRESS, CITY, STATE, ZIP CODE 61 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEPICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X6) COMPLETION DA7E
F 514	diagnoses of diabete The MDS indicated R and antipsychotic me R38 had an admission pharmacy consultant review for January, F. May, June, July, Augit October 2015, were r. R61's admission MDS diagnoses of depression had been taking an antipsychotic review for January, F. May, June, July, Augit October 2015, were r. R76's quarterly MDS diagnoses of dementification and post in disorder. The MDS in taking antipsychotic r. R76 had an admission pharmacy consultant review for January, F. May, June, July, Augit October 2015, were r. R109's quarterly MDS diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses of anxiety diagnoses.	dated 10/26/15, Included as mellitus and dementia. 38 had been taking insulin dications. In date of 4/1/13, the verification of medication abruary, March, April, lust, September and atted 10/29/15, Included on. The MDS indicated R61 tildepressant medication. In date of 4/11/13, the verification of medication abruary, March, April, lust, September and atted in R38's chart. In dated 8/13/15, included its anxiety disorder, traumatic stress dicated R76 had been medications. In date of 10/16/09, the verification of medication abruary, March, April, lust, September and medication of medication abruary, March, April, lust, September and not filed in R38's chart. In dated 9/14/15, included its order, depression, included its order, depression,	F	514			
	dementia and a psychol indicated R109 had tak	otic disorder. The MDS ten antipsychotic.					

	OF DESICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDÉNTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B:WING			11	/18/2015
	ROVIDER ÖR SUPPLIER RE RESIDENCE & REHA	B CTR		STREET ADDRESS, CHY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PRESIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (FACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 519	R109 had an admissic pharmacy consultant review for January, Fe June, July, August, Se 2015, were not filed in During interview on 11 assistant director of me pharmacy consultant I with the October 2015 medication review ver were now individualized were kept in the ADOI Individual resident's medication review ver previously sent via enresident's medical received to contact the conprovide documentation review's prior to October 2015.	epressant medications. In date of 11/11/14, the verification of medication abruary, March, April, May, eptember and October 1838's chart. In 18/15, at 9:44 a.m. the ursing (ADON) stated the had started a new process in pharmacy consultant's ification forms. The forms and by resident and they N's office in a file, not in an edical record. The ADON pharmacy consultant's lification forms were mail and were not filed in the lord. The ADON verified she isultant pharmacist to not the medication per of 2015. Cords was requested and	F 5	514	 No residents were affected by the a deficient practice. All residents have the potential to be affected by the practice. The pharmacy consultant reports we now be individualized and filed in the residents chart. An audit will be completed each me for three (3) months to monitor the pharmacy consultant reports /recommendations have been filed in tresident's chart. These audits will be presented to the monthly QAPI comm for three months. The Director of Nursing/designee were sponsible with oversight from the Administrator. Completion date of 12-31-2015. 	e ill onth he	
	In accordance with sec facility (other than a nu- focated in a State on a have in effect a written one or more hospitals under the Medicare an reasonably assures that transferred from the fa	in Indian reservation) must transfer agreement with approved for participation and Medicaid programs that			 No residents were affected by the alpractice. All residents have the potential to be affected by the practice. 		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A BUILDING				
		245227	B. WING			11/	18/2015
	ROVIDER OR SUPPLIER RE RESIDENCE & REHA		•	160	REET ADORESS. CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JEUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y WUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(D PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) GOMPLETION DATE
F 519	by the attending physinformation needed for residents, and, when deems it appropriate, such residents can be less expensive setting the hospital, will be elimitated in agreement in effect it good faith to enter in hospital sufficiently contrained from the potential sufficiently contrained in a feet and potential to affect all facility. The Transfer Agreement hospital formation in a feet all facility. The Transfer Agreement hospital formation in a feet all facility. The Transfer Agreement hospital facility. During an interview of administrator verified be updated. The administrator verified be updated in owners.	appropriate, as determined sician; and medical and other or care and treatment of the transferring facility, for determining whether e adequately cared for in a githan either the facility or exchanged between the sered to have a transfer of the facility has attempted in the an agreement with a lose to the facility to make of its not met as evidenced and document review, the relative a transfer agreement with the serious current. This had the serious current approvider. The serious the facility and the serious and hospital provider. The serious the facility and the serious and hospital provider. The serious the facility and the serious and hospital provider. The serious the facility and the serious and hospital provider. The serious the facility and the serious the serious for the se	F	519			

Facility ID: 00589

	OF DEPICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			11	/18/2015
	ROVIDER OR SUPPLIER	B CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		GO1 ST LOUIS AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATRIMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) CXMPI FTION DATE
F 519	Continued From page A policy for contract o not provided.	115 r agreement renewals was	i	519		been erly	
				:		:	Ē

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 11/12/2015 245227 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1601 ST LOUIS AVENUE **BAYSHORE RESIDENCE & REHAB CTR DULUTH. MN 55802** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 l 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 10 Maris 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, State Fire Marshal Division. 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 DEC 18 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. MN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISION PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

12-15-2015

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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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245227	B. WING			11/	12/2015
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	EHAB CTR		1	STREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page Or by email to: Marian.Whitney@stor Angela.Kappenman THE PLAN OF COF DEFICIENCY MUST FOLLOWING INFO 1. A description of wear to correct the deficite 2. The actual, or process 3. The name and/or responsible for correct or prevent a reoccur Bayshore Health Coes a no basement. The constructed in 1969 original building buil Type II (111) constructed as or The building is fully	ge 1 cate.mn.us @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE RMATION: what has been, or will be, done ency. posed, completion date. title of the person ection and monitoring rrence of the deficiency enter is a 2-story building with e original building was with an addition in 1978. The dings and additions are all uction, therefore, the facility		000			
	department notificat	itored for automatic fire ion.					
		ensed capacity of 139 sus of 108 at the time of					

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Event ID: GYQH21 Facility ID: 00589

If continuation sheet Page 2 of 7

DON BABBUT Administration 12-15-2015

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPL	(X3) DATE SURVEY COMPLETED		
		245227	B. WING			11/	12/2015
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	EHAB CTR					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	NOT MET as evider NFPA 101 LIFE SA One hour fire rated fire-rated doors) or a extinguishing syster and/or 19.3.5.4 prot the approved autom option is used, the a other spaces by sm doors. Doors are se field-applied protect	42 CFR Subpart 483.70(a) is need by: FETY CODE STANDARD construction (with ¾ hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When natic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or ive plates that do not exceed pottom of the door are	K		 The soiled utility room the 1 Center door were The doors were repaired Environmental rounds 12-14 2015 to monitor assuring all doors in the function properly. Round conducted two (2) time 12 weeks to monitor ed. The results of the documentation of the committee for review are recommendations. The Director of Maintage and the properties of the documentation. The Director of Maintage and the properties of the documentation. 	were in a cour property of the cour property of the cour property of the course of the	2-1-2015. nitiated on ocess for ity II be week times nce. tion will be will be

This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors.

Findings include:

On facility tour between 2:00 PM to 5:00 PM on 11/12/2015, observation revealed, that Soiled Utility rooms 175A and in 1 Center did not

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Event ID: GYQH21

Facility ID: 00589

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245227	B. WING		-	11/	12/2015
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	EHAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Maintenance Super	the frame. ion was verified by the	K 0				
SS=D	Heating, ventilating, with the provisions of in accordance with the secondary to the secondary terms of the second	and air conditioning comply of section 9.2 and are installed			 The smoke and fire da subsequent documenta completed on 12-1-20 The maintenance reconvil be presented to the 	ntion was	as imentation
	Based on observation revealed that the faci- part of the air distributup air for the sleeping throughout the building with NFPA 90A. This the products of combifire origin and negative	not met as evidenced by: ns and an interview, it was lity is using the corridors as tion system to provide make- g rooms' bathroom exhaust, ng which is not in accordance deficient practice could allow ustion to travel far from the rely affect all residents, staff ting their means of egress in a			committee for review. 3. The Director of Mainteresponsible with over a Administrator.		

Findings include:

On facility tour between 2:00 PM to 5:00 PM on 11/12/2015, it was revealed during the review of the

facility's fire and smoke damper test/inspection documentation and interview with the Maintenance Supervisor, that the facility could not provide any documentation for the smoke and fire damper testing at the time of the inspection.

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Facility ID: 00589

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245227 11/12/2015 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1601 ST LOUIS AVENUE BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 067 Continued From page 4 K 067 This deficient condition was verified by the Maintenance Supervisor. K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 SS=C Electrical wiring and equipment is in accordance 1. The extension cords were removed from room 235 by 12-1-2015. Observation rounds will be eenducted two (2) times per week times 12 weeks to monitor the facility follows its policy of restricing the use of extension cords in resident rooms. 3. This documentation will be presented to the monthly OAPI committee for review. 4. The Director of Maintenance will be responsible with oversight by the with NFPA 70, National Electrical Code. 9.1.2 Administrator. This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was not limiting storage near electrical devices in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors of the facility. Findings include: On facility tour between 2:00 PM to 5:00 PM on 11/12/2015, observations revealed that in Room 253 the facility failed to limit the use of extension cords. This deficient condition was verified by the Maintenance Supervisor.

K 154	NFPA 101 LIFE SAFETY CODE STANDARD	K 154	
SS=D		K 154	
	system has been returned to service. 9.7.6.1		

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Facility ID: 00589

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		E CONSTRUCTION D1 - MAIN BUILDING 01		E SURVEY MPLETED
		245227	B. WING			11/12/2015	
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	EHAB CTR		16	REET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 154	Based on a record facility has failed to acceptable written per followed in the esprinkler system has for four or more house deficient practice conformers early response a would affect the saft and staff. Findings include: On facility tour between 11/12/2015, during documentation and Maintenance Superfacility could not profire sprinkler system.	s not met as evidenced by: review and staff interview, the provide a complete and colicy containing procedures to vent that the automatic fire is to be placed out-of-service irs in a 24 hour period. This culd affect the facility's ability and notification of a fire and ety of all residents, visitors een 2:00 PM to 5:00 PM on a review of available an interview with the visor, it was found that the vide a complete automatic in out of service policy.	K 1	54	 The Automatic Fire Syst Policy or the "Fire Waterevised and updated per the Director of Maintena 12-1-2015. Fire and Life Safety polireviewed at the monthly for three (3) months. The Director of Mainten responsible with oversig Administrator. 	h" Policithe regressions. Concern Conc	lations by ompleted ll be committee

K 155 NFPA 101 LIFE SAFETY CODE STANDARD SS=D

Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period,

K 155

the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been

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Facility ID: 00589

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245227	B. WING		11/12/2015		
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 155	· ·		K 1	TAG CROSS-REFERENCED TO THE APPRO		e Watched per ector of ted 12-olicies ly QAI montenance	h" policy the 1-2015 will be PI hs.
1	on 11/12/2015, duridocumentation and Maintenance Super	een 2:00 PM to 5:00 PM ng a review of available an interview with the visor, it was found that the vide a complete automatic					

This deficient condition was verified by the

fire alarm system out of service policy.