



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 29, 2025

Administrator
Bayshore Residence And Rehabilitation Center
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: April 17, 2025

Dear Administrator:

On May 23, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Correction of the Life Safety Code deficiency cited under K521 - HVAC at the time of the April 17, 2025 standard survey, has not yet been verified. Your plan of correction for this deficiency including your request for a temporary waiver with a date of completion of August 1, 2025, has been approved. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 25, 2025

Administrator
Bayshore Residence And Rehabilitation Center
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: April 17, 2025

Dear Administrator:

On April 17, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 17, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 17, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

Bayshore Residence And Rehabilitation Center

April 25, 2025

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 05/21/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/17/2025
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE AND REHABILITATION CENTER			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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 4/14/25 - 4/17/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 4/14/25 to 4/17/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H#: 52272753C MN#: 000109128 H#: 52272754C MN#: 000110491 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/05/2025

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

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F 000	Continued From page 1			F 000			
F 554 SS=D	validate substantial compliance with the regulations has been attained. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documents review the facility failed to remove medications after each use for a resident not approved to keep at bedside. This affected 1 of 1 resident (R33) reviewed for self-administration of medication. Findings include: R33's significant change Minimum Data Set (MDS) dated 3/18/25, identified R33 had intact cognition. Diagnosis included dementia and Parkinson's disease. R33's Self Administration of Medication (SAM) Assessment dated 3/16/25, identified R33 could not identify expiration date of each medication and to continue plan of care. R33's SAM Assessment dated 1/27/25, identified R33 could not identify expiration date of each medication and to continue plan of care. The SAM also identified either R33 did not want to self-administer medications or was unable to determine. R33's care plan undated, lacked documentation			F 554	R33 physician was made aware that resident medication was left at bedside. MD response was recorded in electronic medical record. A new self-administration assessment was completed for R33 and R33's care plan was reviewed and updated as needed. All current residents' self-administration assessments were reviewed, and their care plans were reviewed and updated as needed. Future residents who request self-administering their medication will have a self-administration assessment along with IDT and MD input and self-administration order and care plan will be implemented. The IDT team and Licensed Nurses will be in-serviced on the Self-Administration of Medication policy with emphasis on item #1 that the IDT assesses the cognitive and physical ability to determine if a resident is safe to self-administer medication and the licensed nurse will be in-serviced on the Administering Medication Policy with emphasis on item #27 that residents may self-administer their own medication only if the attending		5/20/25

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F 554	Continued From page 2 related to R33's SAM assessment. During observation on 4/14/25, at 2:16 p.m., a bottle of nystatin powder with R33's name on it was noted on the bedside table in R33's room. During a second observation on 4/16/25 at 7:43 a.m., a bottle of nystatin powder with R33's name on it was again observed on the bedside table in R33's room. During an interview on 4/16/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated to keep medications at the bedside there needs to be a SAM assessment completed that showed the resident was safe to self-administer medication and to keep the medication at bedside. There also needs to be a provider order to keep the medication at bedside. LPN-A entered R33's room and confirmed a bottle of nystatin powder was on R33's bedside table. LPN-A stated R33 did not have a SAM that okayed medications to be kept at bedside because R33 could not self-administer. During an interview on 4/17/25, at 12:31 p.m. registered nurse (RN)-A stated the SAM assessment indicating the resident is cleared to self-administer medication and a provider order needed to be in place before a resident could self-administer medications or keep medications at bedside. During an interview on 4/17/25 at 12:38 p.m., the director of nursing (DON) stated the SAM assessment and provider order need to be in place to store medications at bedside. Facility policy Self-Administration of Medication	F 554	physician in conjunction with the IDT team that the resident has the decision making capability to do so. Director of Nursing and/or designee is responsible for compliance. Audits on self-administration assessment completion, medications left at bedside without self-administration assessment completed and resident compliance to self-administration procedure will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 554	Continued From page 3	F 554			
F 557 SS=D	last reviewed 12/13/21, indicated if the facility determined a resident was not safe to self-administer medications, the nursing staff would administer the medications. The policy did not discuss if it was safe to store medications at bedside if the resident could not safely self-administer medications. Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain respect and dignity for personal space for 2 of 3 resident's (R31, R55) reviewed who had their room searched without consent. Findings include: R31's clinical admission undated, indicated R31 was her own responsible party. R31's significant change Minimum Data Set (MDS) assessment dated 1/13/25, indicated R31 had intact cognition. Diagnoses included heart failure, anxiety and depression. R31's care plan last updated 5/31/24, indicated resident had a behavior problem related to false	F 557			5/20/25
			R31 and R55 met with social services regarding room search that was conducted without consent, the facility policy was reviewed and any concerns voiced were placed on a grievance form. R31 and R55's MD was made aware that illegal substances were brought into the resident room and the MD's response was recorded in the resident record. The facility IDT team will be in-serviced on the Room Search policy with emphasis on gaining verbal consent from the resident prior to room search. Social Services and/or designee is responsible for compliance. Audits on documentation of verbal consent before room search is conducted		

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F 557	Continued From page 4 accusations and blaming others of mistreatment. One documented trigger for behavior listed under interventions was room searches. R31's active order list dated 7/29/24, indicated search room in pairs after each leave of absence, family visit, and as needed. Review of R31's progress notes from 11/1/24 to 4/16/25 indicated the following: - 4/14/25 at 5:54 p.m., writer did a room search with social services and administrator after visitor left. Resident refused search of person and purse. After much discussion regarding choices that have led up to current life choices resident let staff search purse. - 4/10/25 at 5:03 p.m., resident had visitor. Room search completed. Resident allowed but stated: this is a violation of my rights. - 4/8/25 at 10:33 a.m., a Situation, Background, Assessment and Recommendation (SBAR) report was sent to provider that indicated a room search was completed and items found. Recommendations included to restrict leave of absence rights and revoke rights to leave the facility and was signed by the provider. - 4/7/25 at 10:01 p.m., resident son and another visitor came. Resident and visitors went outside at 9:45 and room search was completed. - 4/7/25 at 3:50 p.m. a routine room search was conducted in accordance with facility policy. - 1/2/25 at 9:54 p.m., room search completed as ordered. - 12/5/24 at 9:44 p.m. room search completed. - 11/30/24 at 3:25 p.m. the resident's room was searched this afternoon. (the medical record indicated the resident had been hospitalized from 11/28/24 to 12/3/24).	F 557	will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 557	Continued From page 5 During an interview on 4/15/25 at 2:07 p.m., R31 stated the facility kept performing searches of her room at all times of the day. They come in two at a time anytime I have a visitor and search my furniture, go through the drawers and purse. Sometimes they even try to search me. They never tell me why; they just walk in and start going through my stuff. Sometimes they ask for permission, but I do not consent to the search. When I don't voluntarily consent to the search they keep talking and pushing until I finally given in and say they can search my stuff. During an interview on 4/16/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated there were residents who had orders to search their rooms after visitors had been present or when the resident left the facility and returned. LPN-A confirmed R31 was one of those residents but LPN-had not done any searches in R31's room. LPN-A believed they did need permission before doing any searches. During an interview on 4/16/25 at 7: 56 a.m., the social services designee (SSD) stated she had participated in room searches of R31's property. All searches were done according to facility policy. R31 did not always give consent voluntarily to perform the search, but after talking with her she would eventually give consent. During an interview on 4/16/25 at 11:58 p.m., registered nurse (RN)-A stated staff did not need permission to perform room searches in R31's room. If we had a concern, our policy allowed us to do the room searches based on those concerns. We would ask R31 for permission, but she did not always give it.	F 557			

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F 557	Continued From page 6 During an interview on 4/16/25 at 1:17 p.m., the administrator stated all room searches were done following facility policy. The facility policy Resident Personal Possession Search last reviewed 10/18/22, indicated there would be a reasonable suspicion that a resident had contraband prior to conducting a room/belonging search. Before the search took place, the search must first be approved by the administrator. The items in plain view could be taken by staff. Otherwise, any resident possessions, the resident and/or resident representative must understand why the search was conducted and provided verbal consent before a search of personal items and person was executed. The verbal consent would be documented by the administrator and the provider would be notified by the director of nursing.			F 557			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys,			F 577			5/20/25

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F 577	Continued From page 7 certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent state agency (SA) survey results were readily accessible and post signage and/or notice of the inspection reports within the campus. This had potential to affect all 87 residents, visitors, and their families who could wish to review the information. Findings include: During an observation and interview on 4/14/25 at 12:35 p.m., no posted signs were available for survey results. The receptionist (O)-H stated that the survey results were kept in a green binder, located to the left of the front desk. The binder was stored on a plastic shelf affixed to the counter and secured with a cable; as a result, survey results were reviewed at the front desk rather than in private. The binder was organized with plastic tabs labeled for the years 2023 and 2022, with the most recent survey results dated June, 2023. During an interview on 4/14/25 at 4:31p.m., O-H stated that the administrator was responsible for maintaining the binder containing the state survey			F 577	The survey binder was updated to include the past 3 years of survey results and is now located in the lobby. Signage has also been posted at the facility entrance so that residents and visitors may view. Upon admission, future residents will be informed where the survey results are located. Upon admission, future residents will be informed where the survey results are located. The facility administrator was in-serviced on the Survey Examination Posting Policy with emphasis on item #2 that copies of the most recent survey, revisits and plans of correction is maintained in a 3-ring binder in an area frequented by most residents. Administrator and/or designee is responsible for compliance. Audits on facility survey results for updated reports and the binder location monthly for 3 months then quarterly to ensure sustained compliance. Audits results will be reviewed by the administrator then taken to the QAPI committee for further review and		

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F 577	Continued From page 8 results. During an interview on 4/15/25 at 10:39 a.m., administrator confirmed responsibility for maintaining the binder with the survey results and confirmed the the most recent results available in the binder were from June, 2023. Administrator also confirmed that survey results and complaints from 2024 and 2025 were added to the binder after the survey team entered the building on 4/14/25.	F 577	recommendations. Compliance: 05/20/2025		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584			5/20/25

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F 584	Continued From page 9 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a resident's room was clean and homelike for 1 of 3 residents (R45) reviewed for environment. Findings include: R45's admission Minimum Data Set (MDS) dated 10/31/24, identified an admission date of 10/25/24, and primary diagnosis as orthopedic care following surgical amputation of the right lower leg. During observation and interview on 4/14/25 at 4:02 p.m., R45 stated his room was too dark, there were stains and holes in the walls, one of the blinds wouldn't raise or lower and these things bothered him. On observation, there were several screw holes in the wall between the two windows,			F 584	R45 room was deep cleaned, holes filled, and stains removed, window blinds education was provided to R45 on 05/05/2025. All other facility resident rooms were inspected, and a room priority list was created for rooms needing repair. Rooms needing repair will be repaired over the next 4 months. In addition, room inspection will be conducted prior to resident admitting into a room and terminal room cleaning will occur per facility policy. Housekeeping and Maintenance department employees will be in-serviced on the Cleaning Disinfecting Rooms policy with emphasis on room cleaning at least every 3 days and terminal cleaning when a resident moves, discharges or expires. The Executive Director and/or designee is		

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F 584	Continued From page 10 and multiple streaks of a brownish-black substance four to five inches long on the wall behind his bed and chair that bothered him. The light over the sink area had droplets of a brown, dried substance on it, and a glob of something brown and thick of about 1 inch long on the front of the light. There was one light over the sink, one over his bed, and one over his chair. R45 stated he has complained to staff about this room. During observation and interview on 4/16/25 at 10:53 a.m., maintenance worker (MW)-B stated they didn't have a routine for checking rooms for maintenance issues because they are in and out of the rooms quite a bit. MW-B said when a room is vacated, they check the lights, doors, toilet, sink, drawers, and closet doors. MW-B stated he was familiar with R45's room and they had painted that room shortly after a resident passed, then R45 was the next resident in the room. MW-B stated R45 had complained about the lighting, so he replaced some bulbs, but he wasn't aware of the holes in the wall and would say that wasn't homelike. As far as the stains on the walls and light fixtures, housekeeping would be responsible for those. During an observation and interview on 4/17/25 at 12:18 p.m., housekeeper (HSK)-A stated every room was house kept daily and included wiping down all surfaces, bathroom, sinks, toilet, sweep and mop the floor. Once a month, or if the resident was out of the building, they will do a deep cleaning of the room. HSK-A stated they didn't have a schedule but just kind of do it on their own. HSK-A observed the stains on R45's walls and light fixture, and acknowledged she could wipe them down, but the lights would have to be maintenance. HSK-A confirmed there was a	F 584	responsible for compliance. Audits on daily room cleaning, terminal room cleaning and completed room repairs will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 584	Continued From page 11 process for maintenance requests for things that needed to be fixed. During an interview on 4/17/25 at 2:21 p.m., the administrator stated deep room cleaning was done annually and when there was a vacancy. Maintenance had a list of things to go through, including wall repair. The administrator stated he was familiar with R45's room and declined touring it at this time. The administrator's expectation was for resident's rooms to be clean and homelike. A policy, Homelike Environment dated 12/8/21, identified its purpose was for residents to be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The policy didn't address repairs to walls.	F 584			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 4 residents (R65, R86) reviewed for accuracy of assessments. Findings include: R65: R65's quarterly Minimum Data Set (MDS) dated 2/24/25, identified intact cognition and a diagnosis	F 641	R65 MDS for Insulin Administration frequency was modified. All other residents who receive insulin, their MDS from survey exit until present was reviewed and modified as needed. and R86 MDS was The MDS coordinator will be in-serviced on the RAI Manual Section I pages 7-11 which the IDT team will review the resident diagnosis list and physician documented diagnosis in the last 60 days		5/20/25

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F 641	Continued From page 12 of morbid obesity. Section N of the MDS identified R65 received one injection of insulin during the assessment period. R65's provider orders dated 1/10/24, identified Trulicity (an injectable non-insulin medication used to improve blood sugar levels) one time weekly. R65's medication administration record for February 2025 identified Trulicity administration on 2/21/25. During an interview on 4/16/25 at 10:35 a.m., registered nurse (RN)-B confirmed the only injectable medication R65 was taking between 2/17 and 2/24/25 would have been Trulicity. During an interview on 4/17/25 at 10:42 a.m., RN-E confirmed she was the nurse responsible for R65's MDS of 2/24/25. RN-E stated her process was to review the resident's orders and other charting to gather information. RN-E reviewed the medication list from the assessment period and confirmed R65 was using Trulicity and she must have coded it as insulin. RN-E state accurate MDS' were important because they affect case mix. A policy for MDS completion was requested but not received. R86: R86's MDS dated 4/4/25, indicated R86 was cognitively intact with diagnoses of cancer, atrial fibrillation, and generalized muscle weakness. R86's Care Plan Report last updated on 4/16/25,	F 641	that have a direct relationship with the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look-back period and on Section N of the RAI Manual pages 1 and two that the coordinator is to record the frequency of when insulin and injections were administered. MDS coordinator and/or designee is responsible for compliance. Audits on coding accuracy for section I and section N will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 641	Continued From page 13 listed resident performance eating - independent/set-up help only provide verbal cues to swallow as needed and take small bites. Head should be upright/forward not leaning back when drinking liquid. The care plan did not identify R86 had dysphasia and lacked instruction for supervised meals. R86's Order Summary Report Active Orders as of 4/17/25, included the following orders: -regular diet ground meat texture, thin liquids -ensure mouth is clean before and after every meal, per speech therapy recommendations -eating: staff supervision, provide verbal cues to swallow as needed, take small bites. head upright/forward when drinking liquids, not leaning back every shift. -Speech eval and treat A Swallow Evaluation Document dated 3/14/25, completed by an Essentia Health Speech therapist indicated R86 had oropharyngeal dysphasia characterized by weakness and decreased coordination. The evaluation recommended cues for head positioning, cues for small bites/sips and follow-up therapy after neurology consult. A nursing note entered on 3/24/25, indicated R86 had had an episode where they could not swallow chicken and had coughed it up on their own. The note referred to speech therapy recommendations and orders in chart for supervision with meals. A provider note dated 3/25/25, included the diagnosis oropharyngeal dysphagia and indicated R86 had been prescribed a new diet order for ground meat post choking episode without overt	F 641			

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F 641	Continued From page 14 aspiration. R86's MDS assessment dated 4/4/25, lacked the following coding: -Section I Active Diagnoses failed to identify R86 had a diagnosis of dysphagia. -Section K Swallowing/Nutrition disorder part K0100 did not identify documented symptoms of possible swallowing disorder that had been identified in R86's medical record. -MDS Section GG - Functional Abilities and Goals failed to identify R86 required supervision with eating. During an interview on 4/17/25 2:07 p.m., RN-E explained when completing the MDS documentation for the seven day look back period gets reviewed. We also meet and review GG during facility IDT meetings. R86 should have been coded for supervision with meals, the risks factors for swallowing should have been coded and the dysphagia diagnosis should have been coded and added to R86's active diagnoses. It is important for these things to be coded correctly so additional changes can be made to update the resident's plan of careplan and the Kardex for staff to follow. The policy Electronic Transmission of the MDS dated 12/19/21, indicated the MDS coordinator was responsible for all ensuring all appropriate edits were completed prior to the transmission of MDS data.	F 641			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684			5/20/25

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F 684	Continued From page 15 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure fluid restrictions were monitored for 2 of 2 residents (R5, R31) reviewed for quality of care. In addition, the facility failed to notify the provider upon resident refusal of medication and when a resident's weight went outside prescribed parameters for 1 of 1 resident (R45). Findings include: R5: R5's quarterly Minimum Data Set (MDS) assessment dated 2/26/25, indicated R5 had intact cognition. Diagnoses included anemia and end stage renal disease. R5 currently received hemodialysis. R5's care plan dated 11/14/24 indicated a risk for altered fluid balance related to (R/T) kidney disease and heart disease: 1200 milliliter (ml) fluid restriction. R5's provider orders dated 3/15/25 indicated a 1200 ml fluid restriction to be documented on each shift. Review of R5's medical record indicated the following:	F 684	R5 and R31's MD were contacted for resident fluid restrictions were not monitored per MD order. R45's MD was contacted to inform that the resident's weight went outside prescribed parameters. The MD's response was recorded and new orders were requested. R31's fluid restriction was discontinued. R5 and R31's care plans were reviewed and updated as needed. All current residents who have fluid restrictions and/or vital sign parameters were reviewed and MDs were updated on residents' noncompliance to parameters as needed. Facility nurses will be in-serviced on the Weight Assessment and Intervention policy which instructs that if a weight change of 5% or more since last weight, resident will be reweighed and the dietitian will be contacted, care plan and interventions revised as needed. Licensed nurses, nurse aides and trained medication aides will be in-serviced on the Encouraging/Restricting Fluid policy with focus on accurately recording nursing and dietary intake and recording the total amount of fluids consumed during the shift and reporting noncompliance to the attending physician.		

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F 684	Continued From page 16 - On 4/9/25 1580 ml of fluid was received - Fluid intake documentation was missed on 3 shifts, NA was charted on 3 shifts and an X was charted on 3 shifts instead of that shift's fluid intake. R31: R31's significant change MDS assessment dated 1/13/25, indicated R31 had intact cognition. Diagnoses included anemia, heart failure, and renal insufficiency. R31's care plan last revised on 1/31/25, indicated resident had congestive heart failure with an intervention that included a 64 ounce/day (1920 ml) fluid restriction. R31's orders dated 7/29/24 indicated a 64 ounce/day (1920 ml) fluid restriction to be charted on every shift. Review of R31's treatment records for 1/25-4/25 indicated the following: - During month of 1/25 3 shifts did not document any kind of intake, and 13 shifts documented "NA" instead of an intake number. - During the month of 2/25 9 shifts did not document any kind of intake, and 6 shifts documented "NA" instead of an intake number. - During the month of 3/25 7 shifts did not document any kind of intake, and 5 shifts documented "NA" instead of an intake number. - During the month of 4/25 4 shifts did not document any kind of intake. During an interview on 4/16/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated dietary would send up a set amount of liquid with each			F 684	Director of Nursing and/or designee is responsible for compliance. Audits on fluid and weight parameters and MD notification of noncompliance will begin 2x a week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 684	Continued From page 17 meal. Nursing staff also had a set amount of fluid that could be given outside of mealtime. The nurse assistants kept track of the numbers and gave them to nursing to enter in the computer each shift for a total amount every 24 hours. LPN-A confirmed R5 and R31 were on fluid restrictions of some kind. During an interview on 4/16/25 at 10:59 a.m., registered nurse (RN)-C stated nursing entered the total number of intakes each shift. She confirmed R5 and R33 had shifts that either had no documentation or "NA" as documentation for the month of 4/25. Keeping track of fluid intake when residents have ordered fluid restrictions was important because of the increased risk of fluid overload for residents with heart failure or on dialysis. During an interview on 4/16/25 at 11:18 a.m., the director of nursing (DON) stated fluid intake should be documented on all shifts. A fluid restriction policy was not provided. R45: R45's significant change in status Minimum Data Set (MDS) dated 3/18/25, identified intact cognition and diagnoses of atrial fibrillation (an irregular heart rhythm), morbid obesity, chronic kidney disease, hypertension, and chronic obstructive pulmonary disease (COPD, a lung and airway disease which restricts breathing). R45's provider orders dated 3/21/25, identified to weigh R45 every other day in the morning before eating or drinking. Call the Heart Center for			F 684			

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F 684	Continued From page 18 weight gain of three pounds overnight accompanied by any symptoms of fluid retention; Weight gain or loss of five pounds or more in a week. An order dated 3/13/25 identified Torsemide (a diuretic used to treat fluid retention) 20 milligrams (mg) one time daily. R45's care plan dated 3/24/25, identified a risk for ineffective peripheral tissue perfusion related to edema (excess fluid). Interventions included evaluating for edema, to educate R45 on the necessity to provide care and treatment due to his history of refusing medications and treatments, to notify provider of new-onset findings, and to provide verbal feedback to resident. R45's electronic medical record (EMR) for April 2025 identified the following weights: -4/10 366.4 -4/12 373 -4/14 R45 refused to be weighed. -4/16 380.4 On 4/16/25, R45's medication administration record (MAR) for April 2025, identified R45 refused torsemide from 4/10/25 through 4/16/25. R45's progress notes in the EMR didn't reflect provider notification of weight gain or refusals of medication. During an interview on 4/14/25 at 3:53 p.m., R45 stated he refused the diuretic because it made him go to the bathroom so much, he couldn't control his bladder, so he refused it daily. During an interview on 4/16/25 at 1:40 p.m., licensed practical nurse (LPN)-B confirmed she	F 684			

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F 684	Continued From page 19 was the nurse caring for R45 today. LPN-B stated the provider was aware of R45's refusals of torsemide and they normally make a progress note when they update the provider, but sometimes information got put in a provider rounding book which was not part of the EMR. LPN-B stated would call the provider if a resident's weight was up or down five pounds, otherwise they fax the weights to the heart center every couple of months. During an interview on 4/16/25 at 1:55 p.m., registered nurse (RN)-B nurse manager stated she wasn't aware R45 had been missing his diuretic or had weight gain. RN-B stated she would expect the nurse to update the heart center with five pound or more gain or loss. For R45, the risk of having too much fluid would be going into heart failure. During an interview on 4/17/25 at 1:23 p.m., RN-B nurse manager stated she had found an SBAR (acronym for situation, background, assessment, and recommendation) communication on 4/10/25 updating the provider of torsemide not taken that day. The communication wasn't part of the EMR. During an interview on 4/17/25 at 3:54 p.m., the director of nursing (DON) would expect a provider be notified when a resident with weight parameters gained weight and would expect vital signs and an assessment be done when a resident like R45 gains weight, and that the weights were reported to the provider. A policy, Refusal of Treatment dated 6/30/21, identified the facility shall honor a resident's request not to receive medical treatment as			F 684			

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F 684	Continued From page 20 prescribed by their physician, as well as care routines outlined on the resident's assessment and plan of care. The policy identified if a resident refused a treatment the unit manager, DON, or charge nurse would interview the resident to determine why they were refusing and to try address the concern. Detailed information about the resident refusal should be documented in the medical record. Documentation must contain the date and time of attempted treatment or medication, what was refused, the resident's response and reason for refusing, the name of the person attempting the treatment or medication, that the resident was informed of the reason for the treatment and possible consequences of not receiving the medication or treatment, date and time physician was notified, and the resident's condition. Notification of physician must be made in a time frame determined by the resident's condition and potential serious consequences of the refusal.			F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			F 686			5/20/25

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F 686	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure weekly skin checks were performed for a resident who developed a pressure ulcer in the facility, to ensure the resident care plan included the presence of actual pressure ulcers, with individualized interventions based on assessment to include turning and repositioning frequency, the presence of integrated wound therapies, an actual wound infection, and manufacturer's recommendations for checking inflation of a Roho (specially designed inflatable wheel chair cushion) for 1 of 2 (R21) residents reviewed for pressure ulcer care. Findings include: R21's quarterly Minimum Data Set (MDS) dated 3/6/25, identified intact cognition and diagnoses of multiple sclerosis (MS), quadriplegia, muscle weakness and unstageable pressure wound to left buttock. The MDS identified R21 had limited range of motion in the upper and lower extremities and needed maximum assistance with bed mobility. The 3/6/25 MDS indicated a risk for pressure sores but no actual pressure sore. R21's provider orders identified: -Weekly skin checks on bath days, with a revision on 3/31/25 to include checking the Roho cushion to make sure it was inflated every Tuesday evening. -On 4/4/25 an order for protein supplement shakes three times per day and sulfamethoxazole-trimethoprim (an antibiotic used to treat infections) for 10 days for wound infection.	F 686	R21 MD was contacted to inform them that the resident weekly wound assessments were not completed timely nor was the cushion inflated appropriately. R21's pressure injury care plan interventions were reviewed and updated as needed and R21's MDS for 3/6/2025 was reviewed and modified. All current residents with pressure injuries, their weekly wound assessments, care plan interventions were reviewed and updated as needed. Future residents' weekly skin will be assessed and completed thoroughly and care plan interventions implemented per facility policy. Licensed nurses will be in-serviced on the Pressure Ulcer Skin protocol with emphasis on items #1 and 2, that the practitioner will assess, and document risk factors and licensed nurses will assess the wound, measure, assess pain and current treatments and support surfaces and nurses must contact MD if new wounds develop or wound declines. The Director of Nursing and/or designee is responsible for compliance. Audits on pressure injury location, interventions including surface devises/turning, and timely weekly wound documentation will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations. Director of Nursing and/or designee is		

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F 686	Continued From page 22 -On 4/10/25 an order for Dakin's half-strength to left ischial tuberosity (bony prominence under buttock) every day shift, cleanse with wound cleanser, apply Dakin's wet to dry, cover with abdominal pad and tape in place. R21's care plan dated 6/17/24 identified a risk for pressure ulcer development related to diagnoses with interventions to monitor for signs and symptoms of infection, administer pain medication as ordered, pressure reducing custom cushion in wheelchair, pressure reduction mattress, weekly treatment documentation, and a new intervention dated 4/9/25 to check Roho cushion for proper inflation. R21's care plan also identified a risk for infection related to chronic wound dated 4/11/25 with interventions to evaluate for signs and symptoms of infection, and to put enhanced barrier precautions in place. R21's electronic medical record (EMR) identified the following: -3/18/25 Weekly Bath Audit V9 completed, no skin issues noted -3/22/25 progress note: Resident had shower this evening. Staff noted redness on perineal/buttock area. Barrier cream applied and oncoming night shift nurse notified. - 3/25/25 progress note: Skin clean, dry and intact. Nothing unusual. - 3/30/25 progress note: Resident has wound to left buttock. Dressing had drainage and odor, cleaned with wound cleanser and covered with foam border dressing. -3/31/25 progress note: Tylenol for sore backside with pain rated 7/10 -3/31/25 first picture and measurements of the wound which measured 7.6 centimeters (cm) by			F 686	responsible for compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 686	Continued From page 23 4.2 cm by 2.4 cm deep. -3/31/25 progress note: Notified that resident has new open area on left buttock. Resident states "My ass hurts, it's like someone put a cigarette out on it" Writer and Nurse manager assessed area. Unstageable pressure injury to left ischium present measuring 4.3 x 2.5 x 0.1 cm. Wound bed is 100% slough with odor present. Foam border dressing applied. Resident is currently on a foam pressure reducing mattress and a ROHO cushion in his wheelchair. ROHO was noted to be flat, resident states that probably has been that way for a while as he noted discomfort while sitting in wheelchair. ROHO was properly reinflated. Eldercare NP notified and saw resident on facility rounds. Received order to cleanse, then apply Santyl and foam border dressing daily and to have Integrated Wound Care (IWC) evaluate and treat on next rounding day. Resident is his own responsible party. -4/1/25 Weekly Bath Audit V9 completed noting open are on left buttock. Old dressing fell off and new dressing completed. -4/3/25 Interdisciplinary Team (IDT) met and reviewed wounds. Resident seen by ADON and LPN NM on 4/2/25. Currently monitoring unstageable pressure injury to left ischium which is new this week. See wound assessment for measurements and orders for treatment. Current interventions include ROHO cushion in w/c and foam mattress in bed, encourage to offload area while in bed. Will add to IWC rounds next week. -4/9/25 Skin and Wound Evaluation form identified a new, unstageable pressure ulcer but didn't have sections filled out for assessment and plan. No other assessments for that wound were located. During an interview on 4/14/25 at 5:57 p.m., R21	F 686			

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F 686	Continued From page 24 stated he had a sore on his bottom, it hurts sometimes but not right now. R21 said they changed the dressing every day. R21 was positioned with a pillow under the left hip. During an interview on 4/15/25 at 2:57 p.m., nursing assistant (NA)-C stated they were positioning R21 every hour when they could, but for sure before two hours. NA-C stated R21 did get up in the wheelchair sometimes, but not so much lately because of his sore, but he wasn't aware of anything special they needed to do with his cushion. NA-C stated he would either look at the care plan or ask someone to know how to care for residents. During an interview on 4/15/25 at 3:15 p.m., physical therapy assistant (PTA)-E confirmed he was currently working with R21 for range of motion in the upper and lower body. They have had to modify the lower body stretches because of the sore on his left buttock. PTA-E stated R21 has had the Roho cushion for as long as he has worked here. PTA-E said as he understands it, the cushion was found to be flat after resident had been using it, and an occupational therapist refilled it. PTA-E wasn't sure if any education was done with staff about the cushion and proper inflation, he would say to check inflation daily, especially if a resident has a sore. In PTA-E's opinion, R21 wouldn't be able to shift his weight on his own even if he was reminded, he needed physical assistance. During an interview on 4/15/25 at 3:34 p.m., NA-E stated she had not been taught anything about R21's Roho cushion, but she would just press on it before using it and if it was good and firm she would use it. If not, NA-E would report to the			F 686			

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F 686	Continued From page 25 nurse. During an interview on 4/17/25 at 9:17 a.m., NA-D stated he knew there was a special cushion for R21's wheelchair but wasn't aware of anything special that needed to be done with it. During an interview on 4/17/25 at 12:14 p.m., licensed practical nurse (LPN)-B confirmed she was familiar with R21 and what they were doing differently since he had a wound was to make sure the Roho cushion was fully inflated. LPN-B added that a spare pump was in his room now, and they were all educated on making sure the cushion was full. LPN-B stated there wasn't repositioning on his care plan yet, they all just knew to reposition him, she would guess it is more frequent than every two hours. During an interview on 4/17/25 at 1:09 p.m., registered nurse (RN)-B nurse manager stated the intervention added to R21's care plan after he developed the wound was to check every week that the Roho cushion was fully inflated. RN-B stated therapy came up and made sure the cushion was properly reinflated after it was found to be flat, and some verbal education was done with floor nursing staff. RN-B stated she wasn't familiar with the Roho cushion manufacturer's directions but could look them up. The assistant director of nursing (ADON) added they relied on the standard of care for repositioning every two to three hours. The interventions on the care plan were all standard, but they could personalize it. The ADON stated the expectation was that weekly bath audits were done weekly, even if the resident refused their bath or shower, they should offer a bed bath, document, and still do the skin inspection. The ADON feels they may have been	F 686			

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F 686	Continued From page 26 able to put interventions in sooner if the skin inspections had been done. During an interview on 4/17/25 at 3:53 p.m., the director of nursing (DON) stated it was her expectation to reposition residents routinely, which was every two to three hours, and she would expect skin inspections to be done weekly. The DON stated it would be impossible to say whether or not the wound would have been found sooner if weekly skin checks were done because they weren't done. A policy, Prevention of Pressure Injuries dated 9/29/21, identified its purpose was to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The policy indicated all residents at risk for or with actual pressure ulcers will be repositioned on an individualized schedule as determined by the interdisciplinary care team. A document submitted by the facility, Annual Education dated November 2024, identified mandatory education topics for NAs. Topics listed included positioning and wound reporting, but the document didn't contain information on the curriculum. Education material provided to staff regarding Roho cushion inflation was requested but not received.	F 686			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If	F 700			5/20/25

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F 700	Continued From page 27 a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess prior to resident use of bed rails for 1 of 1 resident (R52) reviewed for bed rail use. Findings include: The Guidance for Industry and Federal Drug Administration (FDA) Staff, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment issued on 3/10/24, indicated a comprehensive assessment to prevent entrapment should be looked at when bedrails are considered for a resident. The comprehensive assessment included seven zones to look at and take measurements of which included the following:			F 700	R52 was reassessed by therapy for the use of bed rails. Alternative devices will be trialed and successfully implemented if needed. If alternative devices are unsuccessful, the resident will be provided with bed rail safety information, a risk vs benefit along with documented alternatives attempted and electronic signature obtained. An impaired mobility care plan will be initiated, and positioning aid will be entered into the intervention, implemented and reviewed quarterly and as needed. All existing and future residents' functional status for Bed Rail usage will be documented and residents who require use of bed rail, the facility will follow Bed Rail policy and procedures. Licensed nurses, facility therapy		

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F 700	Continued From page 28 Zone 1: Within the rail Zone 2: Under the rail, between the rail supports or next to a single rail support. Zone 3: Between the rail and the mattress. Zone 4: Under the rail and the mattress. Zone 5: Between split bed rails. Zone 6: Between the end of the rail and the side edge of the head or footboard. Zone 7: Between the head or foot board and the mattress end. R52's quarterly Minimum Data Set (MDS) dated 3/6/25, indicated R52 had moderate to severe cognitive impairment. Diagnoses included dementia, Huntington's disease and depression. Section G- Functional Abilities and Goals indicated R52 had impairments to both sides of the upper and lower body and was dependent for all mobility needs. R52's care plan dated 4/17/25, indicated a physical mobility impairment related to Huntington's disease and intervention included assist resident to perform movements/tasks. It further identified an activity of daily living self-care need with interventions that included extensive assist of two staff to turn and reposition in bed. Bedrail in place to promote independence. R52's Bedrail Risk Assessment (BRA) dated 9/13/24, indicated four sections are looked at: - Section one looked at risk of climbing out of bed, resident confusion state and if bedrails present a higher risk to falling out of bed. - Section two looked at has an alternate to bedrails been looked at, can resident roll, slip or slide out of bed; has resident been consulted about rails; does resident understand the purpose			F 700	department employees and the IDT team will be in-serviced on the Bed Safety and Bed Rail on the entire policy with emphasis on assessment, care planning and ongoing review. In addition, maintenance will use the Bed Entrapment Grid provided through our electronic maintenance system to ensure all beds are audited and safe to use. Director of Nursing and Director of Rehab is responsible for compliance. Audits on risk vs benefit signed consent, bed rail assessment, care plan initiation and documented alternative device attempt will be completed weekly x 3 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 700	Continued From page 29 for bedrails, is family involved. - Section three looked at is the resident small in stature, does the resident have a large head, is there a gab between the lower rail and the mattress will the bedrail fall off the bed and if any of the mentioned will create an entrapment hazard? - Section four looked at the gap between the bedrail and the headboard, if the bedrail fits correctly, is secure, is compatible with the bed and in working order. The BRA lacked information related to zone 1, Zone 2, the footboard portion of zone 6, and zone 7. The BRA also lacked documentation what alternatives were attempted prior to the use of bedrails. On 4/14/25 at 2:27 p.m., R52's bed was observed and there was a half bedrail attached to both sides of the bed, in the middle of each side of the bed. During an interview on 4/15/25 at 11:48 a.m., the maintenance supervisor (MS) stated when a request is made for a bedrails, they made sure there were provider orders entered into the resident medical record. Once orders were confirmed the bedrails would be placed on the bed. The MS stated they did not do any measurements or other items related to bed assessments that involved concerns related to entrapment. During an interview on 4/16/25 at 12:33 p.m., the administrator stated therapy department did the evaluations each time bedrails were recommended for a resident and assessments were completed based on policy.			F 700			

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F 700	Continued From page 30 During an interview on 4/17/25 at 8:55 a.m., physical therapy assistant (PTA)-A stated she performed the bedrail assessments for all residents who had bedrails recommended to be placed. The assessment was performed on the same day maintenance placed the rails on the beds. There was a form that was filled out that looked at all parts of the bed and the bedrail to make sure everything is safe. Measurements were taken from the top of the rail to the headboard and then I made sure the gap between the bedrail and the mattress was no bigger than the width of my hand. There were no other measurements taken when risk of entrapment was looked at. PTA-A reviewed R52's BRA dated 9/13/24 and acknowledged she had performed that assessment and this was the most recent/last assessment she had completed. Facility policy Bed Safety and Bed Rails last reviewed 10/18/22, indicated bed frames, mattresses and bedrails would be checked for compatibility and size prior to use. Regardless of mattress type, width, length, and/or depth, bedframe, bed rail and mattress will leave no gap wide enough to entrap a residents head or body. Any gaps in the bed system are within the safety dimensions established by the FDA.			F 700			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including			F 757			5/20/25

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F 757	Continued From page 31 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure indications for use were identified for ordered medications in 1 of 5 residents (R26) reviewed for unnecessary medication. Findings include: R26's admission Minimum Data Set (MDS) dated 4/7/25, indicated moderately impaired cognition with diagnoses of dementia, muscle weakness, Wernicke's encephalopathy (neurological condition caused by a lack of thiamine), hypertension, hypothyroidism, urinary incontinence, type 2 diabetes, and alcohol use in remission. R26's orders reviewed on 4/15/25, identified the following medication orders: -aspirin low dose oral tablet delayed release 81 mg- give one tablet by mouth once a day for "analgesics- nonnarcotic"			F 757	R26 physician medication orders for indications for use were obtained and added to each of R26's medications. All current residents, their medications will be reviewed over the next 90 days and will have the appropriate diagnosis and indication of use added to medication orders. Future resident admissions, the resident diagnosis and indication for use will be obtained by the physician and added to resident medication orders. The facility HIM, HUCs and Licensed Nurses will be in-serviced on the Psychotropic Medication Policy with emphasis on item #2 which directs the reader that the diagnosis and indication for use is needed for review for the use. Director of Nursing and/or designee is responsible for compliance. Audits on resident medication diagnosis and indication for use and clarification of		

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F 757	Continued From page 32 -atorvastatin 40 mg- give one tablet by mouth at bedtime for "antihyperlipidemics, chemicals" -finasteride oral tablet 5 mg- give one tablet by mouth once a day for "genitourinary agents, miscellaneous, dermatologicals" -levothyroxine oral tablets 112 micrograms (mcg)- give one tablet by mouth once a day for "thyroid agents, chemicals" daily at 6:00 a.m. -pantoprazole sodium delayed release oral tablet 20 mg- give one tablet by mouth twice a day for "ulcer drugs/antispasmodics/anticholinergics, chemicals" -psyllium oral powder 28.3%- give one packet by mouth once a day for "laxatives" -solifenacin succinate oral tablet 5 mg- give one tablet by mouth once a day for "urinary antispasmodics" -tamsulosin oral capsule 0.4 mg- give two capsules by mouth once a day for "genitourinary agents-miscellaneous" -thiamine oral tablet 100 mg- give two tablets by mouth once a day for "vitamins" with supper -vibegron oral tablet 75 mg milligrams (mg)- give one tablet by mouth once a day for "urinary antispasmodics" During interview on 4/16/25 at 10:18 a.m., trained medication aide (TMA)-A stated medication orders typically have indication for use that can be seen on the medication administration record. TMA-A verified medications listed did not seem to have an indication. During interview on 4/16/25 at 10:24 a.m., registered nurse (RN)-B stated medications should have an indication for use listed. RN-B reviewed R26's medication list and verified lack of indications.			F 757	orders upon admission for diagnosis and indication will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 757	Continued From page 33 During interview on 4/17/25 at 10:45 a.m., licensed practical nurse (LPN)-C stated an indication needs to be on the medication order and it is important for clarity of why a resident received medication. LPN-C stated the indication is usually one of a resident's diagnoses. During joint interview on 4/16/25 at 10:28 a.m., RN-C verified lack of indications for medication listed in R26's medical chart. Director of nursing (DON) and RN-C stated expectation for medication orders to have indications such as a diagnosis or condition.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758			5/20/25

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F 758	Continued From page 34 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure behavior monitoring and gradual dose reduction (GDR) or justification of continued use was identified for 1 of 5 (R5) residents reviewed for unnecessary medication who were on a psychotropic medication. In addition, the facility failed to ensure ordered medication had an indication for use for 2 of 5 residents (R23, R26) reviewed for unnecessary medication. Findings include:			F 758	R5s medication administration for Buspar never stopped. R5s GDR was responded to on 5/6/2025 and behavior monitoring was also implemented. R5s care plan was also reviewed and updated as needed. Pharmacy reports for March and April were reviewed for GDR requests and these requests will be reviewed and processed as needed. Future GDR requests will be processed per facility policy. R26 and R23s physician medication orders for indications for use were		

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F 758	Continued From page 35 R5: R5's quarterly Minimum Data Set (MDS) dated 2/26/25, identified R9 had intact cognition and had diagnoses that included anxiety, depression, and post-traumatic stress disorder. R5's care plan dated 4/17/25, indicated a history of depression related to disease processes and family history. Interventions included monitor resident for signs/symptoms of depression that included hopelessness, anxiety sadness, insomnia, anorexia, verbalizing negative statements. R5's physician orders dated 3/3/25, indicated, Buspar 15 milligrams (mg) three times a day (TID) by mouth for anxiety and Lexapro 10 mg, 1.5 tablets by mouth daily for major depressive disorder. The orders lacked the date both medications were first started. R5's Consultant Pharmacist's Medication Review dated 2/2/25, indicated a gradual dose reduction (GDR) was due for Buspar 15 mg TID by mouth. The original order dated was 11/1/23. If the GDR is appropriate, consider Buspar 10 mg TID by mouth. If the GDR was clinically contraindicated, please document a rationale to support that decision-either below or in a progress noted. Provider response dated 2/3/25 indicated provider agreed with the GDR recommendation if patient agreeable. On 2/3/25 the director of nursing (DON) wrote patient declined and wanted to stay on current dose. R5's Consultant Pharmacist's Medication Review dated 8/6/24, indicated a gradual dose reduction (GDR) was due for Lexapro 15 mg daily by	F 758	obtained and added to each of the resident ordered medications. All current residents, their medications will be reviewed over the next 90 days and will have the appropriate diagnosis and indication of use added to medication orders. Future resident admissions, the resident diagnosis and indication for use will be obtained by the physician and added to resident medication orders. The facility HIM, HUCs and Licensed Nurses will be in-serviced on the Psychotropic Medication Policy with emphasis on item #2 which directs the reader that the diagnosis and indication for use is needed for review for the use. The IDT team will be in-serviced on the Gradual Dose Reduction Policy with emphasis of reviewing clinical alerts being triggered daily and nurses along with social services follow up for progress note addressing triggered behaviors. Director of Nursing and/or designee is responsible for compliance. Audits on indications for use added into resident medication orders, review of clinical triggered alerts and nursing and social services follow up documentation will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 758	Continued From page 36 mouth. The original order dated was 11/2/23. If the GDR is appropriate, consider Lexapro 10 mg daily by mouth. If the GDR was clinically contraindicated, please document a rationale to support that decision-either below or in a progress noted. Provider response dated 8/23/24, indicated disagree with explanation. Resident stable. R5's provider 30-day review progress notes dated 4/1/25, identified R5 had anxiety and post-traumatic stress disorder currently on Buspar 15 mg three times a day by mouth and Lexapro 15 mg daily by mouth. The 12-point review of systems (ROS) was performed, and positives noted in "HPI and PMH", pertinent negatives reviewed, and otherwise negative. The provider progress notes lacked any documentation that indicated a GDR of Lexapro or Buspar was clinically contraindicated. R5's provider progress notes (PPN) dated 3/21/25, indicated R5 had no complaints at the visit. The PPN identified R5 had anxiety and post-traumatic stress disorder currently on Buspar 15 mg three times a day by mouth and Lexapro 15 mg daily by mouth. The 12-point review of systems (ROS) was performed, and positives noted in "HPI and PMH", pertinent negatives reviewed, and otherwise negative. The provider progress notes lacked any documentation that indicated a GDR of Lexapro or Buspar was clinically contraindicated. R5's physician 60-day review progress notes dated 11/15/24, identified R5 had anxiety and post-traumatic stress disorder currently on Buspar 15 mg three times a day by mouth and Lexapro 15 mg daily by mouth. The 12-point			F 758			

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F 758	Continued From page 37 review of systems (ROS) was performed, and positives noted in "HPI and PMH", pertinent negatives reviewed, and otherwise negative. The provider progress notes lacked any documentation that indicated a GDR of Lexapro was clinically contraindicated. R5's medical record failed to identify behavior monitoring and corresponding nursing assessment either supporting the continuation of the Buspar and Lexapro doses or recommendation of a dose reduction. During an interview on 4/16/25 at 7:46 a.m., licensed practical nurse (LPN)- A stated behaviors would be documented in the computers. I would make a progress note for behaviors that occurred at the time they occurred. LPN-A thought there would be orders in the computer for behavior monitoring and side effect monitoring which would show up on either the medication administration record or the treatment administration record, so staff was aware to document on side effect monitoring and behavior monitoring. Since LPN-A had started in the facility R5 had been very pleasant and had no behaviors or concerns that staff was aware of. During an interview on 4/17/25 at 12:31 p.m., registered nurse (RN)-A stated the pharmacist would send all GDR recommendations to the DON for review. The DON would then send them to the nurse managers to work on and see if appropriate to be performed. During an interview with the DON at 4/17/25 at 12:35 p.m., the DON stated she was part of the GDR decision process. Discussion would occur in IDT and review of resident's medical chart. We			F 758			

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F 758	Continued From page 38 would then relay our findings and recommendations to the provider for final say. If a resident did not want to do the GDR we would not perform one, even if there was no other clinical indication not to do the GDR. The pharmacy consultant (PC) was called on 4/17/25 at 1:18 p.m., but did not answer. The PC did not return call. The facility policy Gradual Dose Reduction Guidelines last updated 11/30/21, indicated a GDR would be attempted after the resident had been in the facility of a newly initiated psychotropic medication had been used for one year. If a GDR request was initiated by pharmacy, the monthly information would be brought forth for discussion. Based on behavior occurrences and documentation review, the determination whether a reduction would be discussed. Documentation of resident behavior monitoring documentation was requested but not provided. R23: R23's annual Minimum Data Set (MDS) dated 1/10/25, indicated largely intact cognition with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting right dominant side, dementia, insomnia, depression, anxiety, type 2 diabetes, and alcohol dependence in remission. R23's order summary reviewed on 4/16/25, contained an order for ramelteon oral tablets 8 milligrams (mg)- give on tablet by mouth at			F 758			

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F 758	Continued From page 39 bedtime for "hypnotics/sedatives/sleep disorder agents." During interview on 4/16/25 at 10:18 a.m., trained medication aide (TMA)-A stated medication orders typically have indication for use that can be seen on the medication administration record. TMA-A verified medication listed for R23 did not seem to have an indication. During interview on 4/16/25 at 10:24 a.m., registered nurse (RN)-B stated medications should have an indication for use listed. RN-B reviewed R23's medication list and verified lack of indication. During interview on 4/17/25 at 10:45 a.m., licensed practical nurse (LPN)-C stated an indication needs to be on the medication order and it is important for clarity of why a resident received medication. LPN-C stated the indication is usually one of a resident's diagnoses. During joint interview on 4/16/25 at 10:28 a.m., RN-C verified lack of indication for medication listed in R23's medical chart. Director of nursing (DON) and RN-C stated expectation for medication orders to have indications such as a diagnosis or condition. DON stated if the medication was an antipsychotic or other psychotropic then indication needs to be there. R26: R26's admission Minimum Data Set (MDS) dated 4/7/25, indicated moderately impaired cognition with diagnoses of dementia, muscle weakness, Wernicke's encephalopathy (neurological condition caused by a lack			F 758			

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F 758	Continued From page 40 of thiamine), hypertension, hypothyroidism, urinary incontinence, type 2 diabetes, and alcohol use in remission. R26's order summary reviewed on 4/15/25, included the following medication orders: -seroquel oral tablet 200 mg- give one tablet by mouth at bedtime for "antipsychotics/antimanic agents" -buspirone oral tablet 30 mg- give one tablet by mouth twice a day for "antianxiety agents, chemicals" with breakfast and supper During interview on 4/16/25 at 10:24 a.m., registered nurse (RN)-B stated medications should have an indication for use listed. During interview on 4/17/25 at 10:45 a.m., licensed practical nurse (LPN)-C stated an indication needs to be on the medication order and it is important for clarity of why a resident received medication. LPN-C stated the indication is usually one of a resident's diagnoses. During joint interview on 4/16/25 at 10:28 a.m., RN-C verified lack of indication for medication listed in R26's medical chart. Director of nursing (DON) and RN-C stated expectation for medication orders to have indications such as a diagnosis or condition. DON stated if the medication was an antipsychotic or other psychotropic then indication needs to be there.	F 758			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761			5/20/25

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F 761	Continued From page 41 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure biologic medications were labeled with a pharmacy label indicating the resident's name and prescription information and to ensure biologic medications were destroyed after their beyond-use-date (BUD) in 1 of 3 medication carts reviewed for medication labeling and storage. This had potential to impact any resident receiving insulin in the Harbor Light community. Findings include: During an observation and interview on 4/17/25 at 1:45 p.m., in the Harbor Light community,			F 761	Harbor Light Medication and Treatment carts were cleaned and any medication that expired or was without a label was destroyed. All other treatment carts, medication carts and medication rooms were cleaned and unlabeled or expired items were destroyed as needed. Future medications that lose their label, the medication will have a temporary label affixed and will await pharmacy replacement label per facility policy. Facility nurses and TMA's will be in-serviced on the Storage of Medication Policy with emphasis on item #4 that all medications that are missing labels will be		

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F 761	Continued From page 42 licensed practical nurse (LPN)-D confirmed there was an insulin aspart 70/30 mix pen in the top drawer of the medication cart. LPN-D stated she was not aware of who this belonged to, they did go through the carts regularly for expired or beyond use medication. LPN-D confirmed with a printed resource on the medication cart indicating insulin aspart was good for 28 days after opening. LPN-D stated the insulin will be destroyed. During an interview on 4/17/25 at 3:56 p.m., the director of nursing (DON) stated she would expect insulin to be labeled with the resident's name, opened-on date and to be removed from use after it reaches the BUD. A policy, Labeling of Medication Containers dated 12/13/21, identified all medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. Medication labels must be legible at all times. Individual resident medications must include all necessary information such as resident name, prescriber's name, name, address, and phone number of pharmacy, name, strength and quantity of the drug, prescription number, date medication was dispensed, cautionary statements, the expiration date and directions for use. The expiration or BUD is checked prior to medication administration.	F 761	returned to the pharmacy. Director of Nursing and/or designee is responsible for compliance. Audits on refrigerated medications and cart medication label presence, expired medications left on the cart or in refrigerator, will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880			5/20/25

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F 880	Continued From page 43 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			F 880			

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F 880	Continued From page 44 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to perform appropriate hand hygiene while doing a brief change for 1 of 1 resident (R52) reviewed for infection control. In addition, the facility failed to ensure a shared glucometer was cleaned and sanitized according to manufacturer's instructions for 1 of 1 resident (R78) reviewed for blood sugar testing, and to ensure hand hygiene and gloves were in place during eye drop administration for 1 of 4 residents (R64) reviewed for medication administration. Findings include: R52: R52's quarterly Minimum Data Set (MDS) dated			F 880	R52 and R64's MD was made aware that proper hand hygiene was not performed during incontinent care. R78's MD was informed that glucometer cleaning was not performed between use. The MD's response was recorded in the resident medical record. There were no ill effects experienced by this deficient practice. Facility staff will be in-serviced on Hand Hygiene Policy with emphasis on item #7 which lists when hand hygiene must take place. Licensed nurses will be in-serviced on the Cleaning/Disinfecting Equipment policy with focus on cleaning reusable equipment before and after use and with the appropriate kill time per manufacturer		

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F 880	Continued From page 45 3/6/25, indicated R52 had moderate to severe cognitive impairment. Diagnoses included dementia, Huntington's disease and depression. Section G- Functional Abilities and Goals indicated R52 had impairments to both sides of the upper and lower body and was dependent for toileting hygiene. The MDS indicated R52 was always incontinent of both bowel and bladder. During observation on 4/15/25 at 1:38 p.m., nurse assistant (NA)-A and NA-B took R52 to his room from the dinning hall. NA-A and NA-B washed their hand and placed gloves on their hand and then transferred R52 to bed utilizing a hoier lift. After transfer to bed NA-A and NA-B pulled R52's pants down and exposed his brief. NA-A undid the dirty brief and pulled the top down flat on the bed, but still under R52's buttocks. At the same time, without removing dirty gloves and hand washing, NA-B gathered the necessary equipment to clean R52. Without washing hands or changing gloves NA-A and NA-B cleaned both sides of R52's groin area with wet wipes. The dirty brief was then removed from under R52's bottom, R52 was turned to the right and then to the left, cleaning both sides while being turned. After cleaning was completed, NA-A placed a clean brief under R52's buttocks, R52 was rolled on his back and the brief was secured over R52's groin area without removing the soiled gloves, washing hands and putting new clean gloves on. R52's pants were then placed back on. Lastly R52 was lifted back into his chair. At this point NA-A and NA-B removed their dirty gloves and washed their hands. During an interview on 4/14/25 at 1:54 p.m., NA-A and NA-B stated they would not change gloves or wash their hands except at the beginning and the	F 880	product policy. Infection Preventionist and/or designee is responsible for compliance. Audits on hand hygiene performed at documented intervals and glucometer cleaning before and after with the appropriate kill time will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 880	Continued From page 46 end of providing peri cares. The only time they would change gloves and wash hands during the process of provided peri cares would be if the glove or skin encountered actual stool. During an interview on 4/16/25 at 2:08 p.m., the infection preventionist/assistant director of nursing (IP) stated gloves needed to be changed and hands washed anytime they were going from dirty to clean when providing peri care. Example given was when the staff finished brief removal and cleaning of the peri area, hands would need to be washed, and gloves changed before placing the new clean brief on the resident. Facility policy Handwashing/Hand Hygiene last updated 8/25/21, indicated hand washing or utilizing alcohol based hand rub would be used: A: before and after coming on duty. B: before and after direct contact with residents. C: before handling clean or soiled dressing, gauze pads etc: D. before staff moved from a contaminated body site to a clean body site during resident cares. R78: R78's quarterly Minimum Data Set (MDS) dated 4/10/25, identified intact cognition and a diagnosis of diabetes mellitus. R78's medical record identified an order dated 10/2/24, for blood sugar testing two times per day. During an observation and interview on 4/16/25 at 7:27 a.m., licensed practical nurse (LPN)-B checked blood sugar for R78 with a facility glucometer. When finished, LPN-B carried the			F 880			

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F 880	Continued From page 47 glucometer back to the medication cart, cleaned it with an alcohol wipe and then set it on top of the cart. LPN-B stated the glucometer was shared between two residents, the rest of the residents either had their own meter or a continuous blood glucose monitor. LPN-B stated her process was to wear gloves when she was using the meter and then to clean it with an alcohol wipe. R64: R64's quarterly MDS dated 2/17/25, identified moderately impaired cognition and diagnoses of hypertension, renal failure, depression and COPD. R64's medical record identified an order dated 2/11/25, for Refresh Liquigel (brand name ophthalmic solution) one drop to both eyes four times per day for dry eyes. During an observation and interview on 4/16/25 at 7:40 a.m., trained medication aid (TMA)-B prepared to assist R64 with Refresh Liquigel. TMA-B got a tissue, leaned R64 back in her chair, tilted her head back, used his left hand to hold her right eye open and applied a drop, he was not wearing gloves. TMA-B then used one hand to hold her left eye open and the other to place one drop in her left eye. R64 stated the drop didn't get in her eye, TMA-B repeated the process and then handed R64 a tissue. TMA-B stated he wore gloves sometimes but not for R64 because she got scared. TMA-B stated it was important to wear gloves when giving eye drops to protect from germs. During an interview on 4/16/25 at 11:46 a.m., licensed practical nurse (LPN)-A stated he would			F 880			

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F 880	Continued From page 48 use purple top wipes to clean the glucometer if he used it, but he hasn't had to use it because the residents on his side either have a CGM or their own glucometer. During an interview on 4/17/25 at 1:28 p.m., the assistant director of nursing (ADON) stated she didn't expect anyone to have a shared glucometer, and if there were she would expect it to be cleaned with purple-top wipes. The ADON also stated she would expect clean hands and gloves when administering eye drops. These were important for infection control. A policy, Administering Medications dated 12/13/21, identified staff will follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable. A policy, Obtaining a Fingerstick Glucose Level dated 9/30/21, identified to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The manufacturer's instructions for the Medline Evencare G2 blood glucose system included two steps. The first step was to clean the machine of any visible soil with a soft cloth and a mild detergent. Cleaning must be done to ensure proper disinfection in the next step. Step two was to disinfect the meter with one of the products validated for use with their meter, listed as: Dispatch Hospital Cleaner Disinfectant towels with bleach, Clorox Healthcare Bleach germicidal and disinfectant wipes, Medline Micro-Kill Bleach germicidal bleach wipes. The glucometer should			F 880			

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F 880	Continued From page 49			F 880			
F 909 SS=D	remain wet with the product for the amount of time designated by product instructions. Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program 1 of 1 resident (R52) reviewed for bed rail safety. Findings include: R52's quarterly Minimum Data Set (MDS) dated 3/6/25, indicated R52 had moderate to severe cognitive impairment. Diagnoses included dementia, Huntington's disease and depression. Section G- Functional Abilities and Goals indicated R52 had impairments to both sides of the upper and lower body and was dependent for all mobility needs. R52's care plan dated 4/17/25, indicated a physical mobility impairment related to Huntington's disease and intervention included assist resident to perform movements/tasks. R52's care plan last updated 4/15/25, indicated an activity of daily living self-care need with			F 909	R52 had a new bed rail assessment completed and the care plan was reviewed and updated as needed. Current residents utilizing bed rails bed rail assessments and care plans were reviewed and updated as needed. For future admissions, the facility bed will have maintenance checks performed per facility policy. The IDT team was in-serviced on the Bed Safety Policy with emphasis on item #6 and #7 that maintenance staff will routinely inspect all beds and related equipment and will provide inspections to the administrator and report results to the QAPI committee for recommendations. Routine bed inspection tasks were added to the TELS maintenance schedule. The maintenance Director and/or designee is responsible for compliance. Audits on bed rail safety checks and reports provided to QAPI for recommendations will begin weekly x 4		5/20/25

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F 909	Continued From page 50 interventions that included resident is an extensive assist of two staff to turn and reposition in bed. A bedrail in place to promote independence. On 4/14/25 at 2:27 p.m., R52's bed was observed and there was a half bedrail attached to both sides of the bed, in the middle of each side of the bed. During an interview on 4/15/25 at 11:48 a.m., the maintenance supervisor (MS) stated when a request is made for a bedrail, they made sure there were provider orders entered into the resident medical record. Once orders were confirmed the bedrails would be placed on the bed. The MS stated they did not do any measurements or other items related to bed assessments that involved concerns related to entrapment. There was no schedule for regular bed inspections, mattresses, or bedrails other than to check the bedrails for looseness and tighten them every month. During an interview on 4/17/25 at 8:55 a.m., physical therapy assistant (PTA)-A stated she performed the bedrail assessments for all residents who had bedrails recommended to be placed. The assessment was performed on the same day maintenance placed the rails on the beds. PTA-A stated there were no routine evaluations performed to make sure there were no changes to a resident's risk to entrapment. During an interview on 4/17/25 at 11:08 a.m., the administrator stated maintenance performed monthly inspections of the bed and bedrail through the TELS system.	F 909	weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/20/2025		

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F 909	Continued From page 51 Facility policy Bed Safety and Bed Rails last reviewed 10/18/22, indicated maintenance staff routinely inspected all beds and related equipment to identify risks and problems including entrapment risks. The maintenance department would provide a copy of inspections to the administrator and report results to the QAPI committee for appropriate action. Copies of the inspection results and QAPI committee recommendations were maintained by the administrator and /or safety committee. Maintenance records for regular bed inspection and maintenance was requested, but not received.	F 909			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on April 16,2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Bayshore Residence & Rehabilitation Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/05/2025

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Bayshore Health Center is a 2-story building with no basement. The original building was constructed in 1969, with an addition in 1978. The original building buildings and additions are all Type II (111) construction; therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor			K 000			

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K 000	Continued From page 2 that is monitored for automatic fire department notification. The facility has a capacity of 139 beds and had a census of 87 at the time of the survey.	K 000			
K 291 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 04/16/2025 between 11:30 AM and 2:30 PM, it was revealed by observation that the emergency light located at the 1st floor nursing station was non-operational. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	The emergency lighting fixture was replaced with a new fixture and was tested successfully on 4/29/2025. All emergency light fixtures were tested 4/24/25 for 30 seconds and documented in TELS Maintenance. No further issues were found. Monthly functional tests will be documented in TELS Maintenance. 90 minute test compliance will be documented annually in TELS Maintenance. Maintenance Director and/or designee is responsible for compliance.	5/20/25	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101	K 311		5/20/25	

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K 311	Continued From page 3 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 04/16/2025, between 11:30 AM and 2:30 PM, observations and staff interview revealed that several ceiling tiles were missing from the IT Closet on the 2nd floor. This condition would delay the activation of the fire alarm and sprinkler system in the event of an emergency. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 311	The ceiling tiles were fitted and installed in the grids of the 2nd Floor IT Closet. Fire caulk and foam were used to assure sealed penetrations. Maintenance inspected all areas of the building to assure vertical openings are enclosed. Maintenance Director and/or designee is responsible for compliance.		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355			5/20/25

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K 355	Continued From page 4 inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2, 7.2.1.2, 7.2.4. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 04/16/2025, between 11:30 AM and 2:30 PM, it was revealed by observation, that there was a fire extinguisher at the first floor nursing station in the secured unit that was free-standing and not secured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	An appropriate hanger mount for the extinguisher was purchased and installed 5/5/25. Maintenance inspected all areas of the building to assure extinguishers were properly stored and secured. Monthly inspections of the fire extinguishers will be conducted and recorded in TELS Maintenance. Maintenance Director and/or designee is responsible for compliance.		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521			5/20/25

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K 521	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/16/2025 between 11:30 AM and 2:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the dampers in the facility had been inspected within four years. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	UHL and LVC have been contracted to complete the full inspection of all fire dampers. Future damper inspections will be scheduled with the reports retained by the Maintenance Director. Maintenance Director and/or designee is responsible for compliance.		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible	K 712			5/20/25

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K 712	Continued From page 6 alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/16/2025 between 11:30 AM and 2:30 PM, it was revealed by a review of available documentation that the facility was not varying times for fire drills by at least 90 minutes. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 712	Maintenance Staff have been educated that all fire drills, including 3rd shift fire drill times shall be conducted under varied times and conditions and that fire drills for each shift need a 90 minute separation from each other moving forward, 3rd shift in particular The drill reports will be maintained in the fire safety book and stored in the Maintenance Director's Office. Maintenance Director and/or designee is responsible for compliance.		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms			K 920			5/20/25

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K 920	Continued From page 7 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/16/2025 between 11:30 AM and 2:30 PM, it was revealed by observation that there were coffee pots and microwaves plugged into power strips located in the 2W Nurse Manager Office and in the Employee Break Room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 920	The power strips were removed from the 2W Nurse Manager Office and the Employee Break Room. All managers have been educated on the proper use of power strips and that no coffee pots, microwaves, or refrigerators are to be plugged into power strips. All areas of the building were inspected by maintenance to assure compliance with K920. Maintenance will complete quarterly 'Power Cords and Extension Cords' audit quarterly to assure compliance with K920 and will be documented in TELS Maintenance. Maintenance Director and/or designee is responsible for compliance.		