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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: PZHW

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2013**
6. DATE OF SURVEY **03/13/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **139** (L18)
13.Total Certified Beds **139** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 04/05/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/01/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/08/2018
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5227

On October 19, 2017, an abbreviated standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of J. At the time of the abbreviated standard survey, conditions in the facility constituted immediate jeopardy to resident health or safety. As a result of the abbreviated standard survey, the Department imposed the Category 1 remedy of State monitoring, effective November 19, 2017.

In addition, we recommended to the CMS RO, imposition of the following enforcement outlined in our letter of November 14, 2017:

- CMP for deficiency cited at F441

On November 17, 2017, the Departments of Health and Public Safety completed a standard survey at this facility. The most serious deficiencies were cited at a S/S level of F. As a result of continuous non-compliance, the Category 1 remedy of State monitoring will remain in effect.

In addition, we recommended to the CMS RO, the following action related to the remedy outlined in our letter of November 14, 2017.

- CMP for deficiency cited at F441, be imposed.

Further, we recommended to the CMS RO, the following additional remedy for imposition:

- Denial of payment for New Medicare and Medicaid Admissions (DPNA), effective January 19, 2018.

If DPNA goes into effect, the facility is subject to a two year loss of NATCEP, beginning January 19, 2017

On January 19, 2018 an onsite PCR was completed at this facility. The facility continued to be in non-compliance for the following F tags:

F-278 -- S/S: D -- 483.20(g)-(j) -- Assessment Accuracy/Coordination/Certified
F-314 -- S/S: D -- 483.25(b)(1) -- Treatment/Services To Prevent/Heal Pressure Sores

As a result of continuous non-compliance, the Category 1 remedy of State monitoring will remain in effect. The following remedies were also recommended in our February 2, 2018 letter the following be imposed

- Civil money penalty for the deficiency cited at F-441
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 19, 2018.
- Prohibition from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Program for two years, effective January 19, 2018.

On March 13, 2018 a third onsite PCR was completed and found the deficiencies corrected as of March 13, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state
monitoring effective March 13, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of February 2, 2018:

- Civil money penalty will remain in effect for the deficiency cited at F-441.
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 19, 2018, be discontinued effective March 13, 2018
- Prohibition from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Program for two years, effective January 19, 2018.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245227 March 22, 2018

Mr. David Uselman,Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Dear Mr. Uselman:

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

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

Effective March 13, 2018 the above facility is recommended for:

139 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered March 22, 2018

Mr. David Uselman, Administrator
Bayshore Residence and Rehab Center
1601 St Louis Avenue
Duluth, MN 55802

RE: Project Number S5227028

Dear Mr. Uselman:

On November 14, 2017, the Minnesota Department of Health informed you that the following enforcement remedy was being imposed:

- State monitoring effective November 19, 2017.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil monetary penalty for the deficiency cited at F-441 (42 CFR 488.30 through 488.444)

This was based on deficiencies found during an abbreviated standard survey completed on October 17, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On November 17, 2017, the Minnesota Departments of Health and Public Safety completed a standard recertification survey. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). We also informed you that during the standard survey, we investigated complaint number H522705 and found that the complaint to be substantiated at F-225 and F-226.

As a result of the standard survey findings, we continued the Category 1 remedy of State Monitoring.

On December 22, 2017, we informed you that compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the October 19, 2017 abbreviated standard survey, as well as the November 17, 2017 standard survey had not yet been verified.

We also informed you in the December 22, 2017 letter that Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Social Security Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying

noncompliance.

Further, the December 22, 2017 letter stated that in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 19, 2018.

As a result, the CMS Region V Office concurred and authorized this Department to impose the following remedies:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 19, 2018; and

- Prohibition from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Program for two years, effective January 19, 2018.

On January 17, 2018, the Minnesota Department of Health completed an onsite Post Certification Revisit (PCR), and on January 25, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on November 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on January 17, 2018. The deficiencies not corrected are as follows:

F-278 -- S/S: D -- 483.20(g)-(j) -- Assessment Accuracy/Coordination/Certified
F-314 -- S/S: D -- 483.25(b)(1) -- Treatment/Services To Prevent/Heal Pressure Sores

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

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

Based on the findings of this visit, we recommended to the CMS Region V Office the following remedies:

- Civil money penalty for the deficiency cited at F-441. (42 CFR 488.430 through 488.444);

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 19, 2018. (42 CFR 488.417 (b)); and

- Prohibition from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Program for two years, effective January 19, 2018.

On March 13, 2018, the Minnesota Department of Health completed an onsite PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 19, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 19, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 13, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 2, 2018:

- Civil money penalty will remain in effect for the deficiency cited at F-441. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 19, 2018, be discontinued effective March 13, 2018. (42 CFR 488.417 (b))

As we notified you in our letter of December 22, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 19, 2018.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: PZHW

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2013**
6. DATE OF SURVEY **01/19/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **139** (L18)
13.Total Certified Beds **139** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Siemsen, HFE NE-II 02/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/08/2018
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5227

On October 19, 2017, an abbreviated standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of J. At the time of the abbreviated standard survey, conditions in the facility constituted immediate jeopardy to resident health or safety. As a result of the abbreviated standard survey, the Department imposed the Category 1 remedy of State monitoring, effective November 19, 2017.

In addition, we recommended to the CMS RO, imposition of the following enforcement outlined in our letter of November 14, 2017:

- CMP for deficiency cited at F441

On November 17, 2017, the Departments of Health and Public Safety completed a standard survey at this facility. The most serious deficiencies were cited at a S/S level of F. As a result of continuous non-compliance, the Category 1 remedy of State monitoring will remain in effect.

In addition, we recommended to the CMS RO, the following action related to the remedy outlined in our letter of November 14, 2017.

- CMP for deficiency cited at F441, be imposed.

Further, we recommended to the CMS RO, the following additional remedy for imposition:

- Denial of payment for New Medicare and Medicaid Admissions (DPNA), effective January 19, 2018.

If DPNA goes into effect, the facility is subject to a two year loss of NATCEP, beginning January 19, 2017

On January 19, 2018 an onsite PCR was completed at this facility. The facility continued to be in non-compliance for the following F tags:

F-278 -- S/S: D -- 483.20(g)-(j) -- Assessment Accuracy/Coordination/Certified
F-314 -- S/S: D -- 483.25(b)(1) -- Treatment/Services To Prevent/Heal Pressure Sores

As a result of continuous non-compliance, the Category 1 remedy of State monitoring will remain in effect. The following remedies were also recommended in our February 2, 2018 letter the following be imposed

- Civil money penalty for the deficiency cited at F-441
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 19, 2018.
- Prohibition from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Program for two years, effective January 19, 2018.

Electronically delivered February 2, 2018

Mr. David Uselman, Administrator
Bayshore Residence & Rehabilitation Center
1601 St. Louis Avenue
Duluth, MN 55802

RE: Project Number S5227028

Dear Mr. Uselman:

On November 14, 2017, the Minnesota Department of Health informed you that the following enforcement remedy was being imposed:

- State monitoring effective November 19,2017.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil monetary penalty for the deficiency cited at F-411 (42 CFR 488.30 through 488.444)

This was based on deficiencies found during an abbreviated standard survey completed on October 19, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On November 17, 2017, the Minnesota Departments of Health and Public Safety completed a standard recertification survey. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). We also informed you that during the standard survey, we investigated complaint number H522705 and found that the complaint to be substantiated at F-225 and F-226.

As a result of the standard survey findings, we continued the Category 1 remedy of State Monitoring.

On December 22, 2017, we informed you that compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the October 19, 2017 abbreviated standard survey, as well as the November 17, 2017 standard survey had not yet been verified.

We also informed you in the December 22, 2017 letter that Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Social Security Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance.

Further, the December 22, 2017 letter stated that in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 19, 2018.

As a result, the CMS Region V Office concurred and authorized this Department to impose the following remedies:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 19, 2018; and

- Prohibition from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Program for two years, effective January 19, 2018.

On January 17, 2018, the Minnesota Department of Health completed an onsite Post Certification Revisit (PCR), and on January 25, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on November 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on January 17, 2018. The deficiencies not corrected are as follows:

F-278 -- S/S: D -- 483.20(g)-(j) -- Assessment Accuracy/Coordination/Certified
F-314 -- S/S: D -- 483.25(b)(1) -- Treatment/Services To Prevent/Heal Pressure Sores

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

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

Based on the findings of this visit, we recommended to the CMS Region V Office the following remedies:

- Civil money penalty for the deficiency cited at F-441. (42 CFR 488.430 through 488.444);

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 19, 2018. (42 CFR 488.417 (b)); and

- Prohibition from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Program for two years, effective January 19, 2018.

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

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

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

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax: #: 651-215-9697

Electronically delivered December 22, 2017

Mr. David Uselman, Administrator
Bayshore Residence & Rehabilitation Center
1601 St. Louis Avenue
Duluth, MN 55802

RE: Project Number S5227028 and Complaint Number H5227075

Dear Mr. Uselman:

On November 14, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on October 19, 2017 that included an investigation of complaint numbers H5227070, H5227071, and H5227072. Your facility was not in substantial compliance with the participation requirements and the condition in your facility constituted immediate jeopardy to resident health or safety.

On November 14, 2017, we informed you that the following enforcement remedy was being imposed:

- State monitoring effective November 19, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil monetary penalty for the deficiency cited at F441. (42 CFR 488.430 through 488.444).

On November 17, 2017, the Minnesota Department of Health and on November 16, 2017, the Minnesota Department of Public Safety completed a standard recertification survey. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. In addition, at the time of the standard survey completed November 17, 2017, an investigated complaint number H5227075 was conducted and found to be substantiated at F225 and F226.

However, compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the October 19, 2017 abbreviated standard survey as well as the November 17, 2017 standard survey have not yet been verified. The most serious health deficiencies in your facility at the time of the abbreviated standard survey was immediate jeopardy to resident health or safety (Level J).

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey

identifying noncompliance. The CMS Region V Office concurs and has authorized this Department to notify you of the imposition of the following remedy:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 19, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 19, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 19, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years, effective January 19, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's

informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R-C 01/19/2018

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

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{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 1/16/18, through 1/19/18, to determine status of deficiencies issued as a result of the survey exited on 11/17/17. During this visit the following regulations were determined to be not corrected. 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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 278} SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	{F 278}		2/14/18

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

Electronically Signed | 02/06/2018

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 278}	Continued From page 1 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 1 of 3 residents (R6) reviewed for pressure ulcers. Findings include: R6's Admission Record printed 1/18/18, indicated R6's diagnoses included below the knee amputation, type 2 diabetes, dementia, and disorders of the arteries, arterioles and capillaries. R6's quarterly MDS dated 1/11/18, indicated R6 had severely impaired cognition, and did not have any behaviors or rejection of cares. The MDS further indicated R6 required extensive assistance with bed mobility, transfers and toilet use. The MDS also indicated R6 did not	{F 278}	Corrective Action: A. The mistake in R6's MDS has been corrected to match the care plan, assessment and residents actual condition. Corrective Actions as it applies to other Residents: A. MDS RN's educated on the procedure the MDS should match the care plan, assessment, and Residents actual condition. B. All Staff educated on findings of F278 and corrective action the Facility has made. C. MDS Nurses reviewed MDS records completed from 1/18/18 to current to assure accuracy with all sections. D. A list of 27 residents with high risk for	

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{F 278}	Continued From page 2 ambulate, required extensive assistance with locomotion, and was always incontinent of bowel and bladder. The MDS identified R6 was at risk for pressure ulcers, but incorrectly identified R6 did not have any healed or unhealed pressure ulcers. R6's care plan revised on 1/9/18, indicated R6 was at risk for pressure ulcers and skin issues related to his non-ambulatory status, a history of pressure ulcer to the sacrum, diabetes, decreased sensation in the foot, incontinence, and the use of psychotropic medications. The care plan indicated R6 had a healed Stage 2 pressure ulcer on his left heel, and a healed Stage 2 pressure ulcer to back of the right thigh. The care plan also directed staff to provide wound care as ordered. On 1/17/18, at 8:55 a.m. an application of a new dressing was observed with licensed practical nurse (LPN)-B. R6 had a pressure ulcer to the left of the coccyx, approximately 1 centimeter (cm) round, and appeared to be a Stage 2. LPN-B stated the pressure ulcer was healed on Monday (1/15/18). A new foam border dressing was applied to R6's coccyx and the pressure ulcer on the left side of the coccyx. LPN-B then removed a soiled dressing from the back of R6's right thigh. This area was pink and appeared healed. LPN-B cleansed the area and applied a new dressing. LPN-B stated they kept a dressing on this healed pressure ulcer for protection. On 1/18/18, at 6:40 a.m. R6's coccyx pressure ulcer was observed with registered nurse (RN)-A. RN-A stated the pressure ulcer on the left side of R6's coccyx was new yesterday. The pressure ulcer measured 1.1 cm x 1.0 cm with pink edges.	{F 278}	pressure ulcers was formed from PointRight. Facility reviewed the care plan, CNA group sheets, and MDS of each resident on the PointRight list and all residents with a current pressure ulcer to assure all areas were matching and accurate. Date of Completion: February 14, 2018 Recurrence will be prevented by: A. Facility will audit every MDS for one month to assure MDS accuracy. After the first month, the facility will perform audits two times per week for three months to assure MDS accuracy. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Administrator	

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{F 278}	Continued From page 3	{F 278}		

The skin surrounding the pressure ulcer was blanchable. RN-A stated the pressure ulcer was a Stage 2 and the slit on the center of R6's coccyx measured 1.3 cm and she could barely see it.

On 1/17/18, at 2:17 p.m. RN-A was interviewed and stated R6 had a history of pressure ulcers that would develop and then heal. RN-A stated last week R6's coccyx had a tiny area where the skin had rubbed off. RN-A stated she had observed R6's skin on 1/11/18, and the area on the back of R6's thigh measured 1.0 x 0.9, but R6's coccyx was clear. RN-A was asked if the pressure ulcer to the left of the coccyx was present between 1/3/18, and 1/9/18. RN-A stated it was classified as a shearing injury, not a pressure ulcer.

On 1/18/18, at 9:42 a.m. LPN-B stated 1/2/18, was when the pressure ulcer to the left of the coccyx was first noticed. LPN-B stated the pressure ulcer was pinpoint size. LPN-B stated on 1/12/18, the pressure ulcer was still there, and on 1/13, and 1/14, it looked to be improving. LPN-B stated the pressure ulcer was almost healed on 1/15/18. LPN-B stated when she saw the pressure ulcer on 1/17/18, it had no dressing and looked worse.

On 1/18/18, at 2:22 p.m. RN-E verified the MDS dated 1/11/18, was an error. RN-E stated R6 did not have a physician's documentation that said R6 had a Stage 2 pressure area, and R6's medical record indicated he had an "area." RN-E stated the MDS should have indicated "Yes" to healed pressure ulcers since last assessment. RN-E stated R6 was at risk for pressure ulcers due to his refusal of cares, dementia, history of pressure ulcers and mobility deficit. RN-E stated

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{F 278}	Continued From page 4 she relied on the progress notes and the Braden Scale for her documentation. RN-E stated she did not know R6 was receiving the application of a foam dressing. On 1/18/18, at 1:42 p.m. the director of nursing (DON) stated she would expect the MDS reflect pressure ulcers and the risk of pressure ulcers. A policy on accuracy of the MDS was requested and not provided.	{F 278}		
{F 314} SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and provide ongoing monitoring of pressure ulcers to prevent the development and	{F 314}	Corrective Action: A. RN's and LPN's re-educated to complete skin assessments weekly and to notify the Nurse Manager if the resident	2/14/18

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{F 314}	Continued From page 5 worsening of pressure ulcers for 1 of 3 residents (R6) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). R6's Admission Record printed 1/18/18, indicated R6's diagnoses included below the knee amputation, type 2 diabetes, dementia, and disorders of the arteries, arterioles and capillaries. R6's quarterly Minimum Data Set (MDS) dated 1/11/18, indicated R6 had severely impaired cognition, and did not have any behaviors or rejection of cares. The MDS further indicated R6 required extensive assistance with bed mobility, transfers and toilet use. The MDS also indicated R6 did not ambulate, required extensive	{F 314}	refuses. B. R6 pressure area was found to be healed on 2/1/18 skin assessment. C. Skin interventions for R6 include: Administer medications as ordered. Monitor/document for side effects and effectiveness. Diabetic nail care to be completed by licensed nurse. Encourage Resident to allow repositioning and turning every two hours and PRN. Document refusals. Resident requires extensive assist of two to turn/reposition. Encourage to get up and in chair throughout the day. Follow facility protocols/practices for the prevention/ treatment of skin breakdown. Keep pressure off coccyx. Heel/achilles floating with nothing touching. No footwear. Avoid trauma to left foot. Nursing to monitor skin weekly on bath days. Staff to monitor skin with all cares and report any changes noted to nursing. Okay to leave lift sheet under resident d/t increased risk for friction and shear. Resident may be resistive to cares/toileting at times, resident may refuse cares/treatments. Staff reproach and document any refusals. Rooke boot to LLE on at all times. Resident has a roho cushion on wheelchair and a low air loss alternating air mattress on bed. Wound care as ordered. D. All Staff re-educated regarding following the Plan of Care and CNA group sheets for repositioning and changing of briefs. E. 'Prevention of Pressure Ulcers' policy reviewed and dated 1/22/18.	

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{F 314}	Continued From page 6 assistance with locomotion, and was always incontinent of bowel and bladder. The MDS identified R6 was at risk for pressure ulcers, but incorrectly identified R6 did not have any healed or unhealed pressure ulcers. The MDS also indicated R6 had a pressure relieving mattress on the bed and a pressure relieving cushion in the wheelchair. R6's Care Area Assessment (CAA) for pressure ulcers dated 10/18/17, indicated R6 was at risk for skin breakdown due to a history of healed pressure ulcers, diagnosis of diabetes, urinary and bowel incontinence, and the need for assistance with mobility. The CAA also indicated R6 had an existing pressure ulcer, but lacked any further description of the pressure ulcer. R6's care plan revised on 1/9/18, indicated R6 was at risk for pressure ulcers and skin issues related to his non-ambulatory status, a history of pressure ulcer to the sacrum, diabetes, decreased sensation in the foot, incontinence, and the use of psychotropic medications. The care plan indicated R6 had a healed Stage 2 pressure ulcer on his left heel, and a healed Stage 2 pressure ulcer to back of the right thigh. Interventions included to administer treatments as ordered and monitor for effectiveness, encourage R6 to allow repositioning and turning every two hours and as needed, encourage side to side repositioning every two hours, encourage R6 to get up in the chair throughout the day, follow facility policies and protocols for the prevention and treatment of skin breakdown, keep pressure off the coccyx, float heel/achilles with nothing touching and no foot wear, keep R6's heel elevated by placing a pillow under the left lower extremity when in bed, Rooke boot (a boot	{F 314}	Corrective Actions as it applies to other Residents: A. All Staff educated on findings of F314 and corrective action the Facility has made. B. Facility assured all Residents with pressure ulcers have current weekly skin assessments. C. Facility reviewed all CNA group sheets to assure they match the plan of care for turning and repositioning residents. D. Facility reviewed all residents with current pressure ulcers and 27 residents with high risk for pressure ulcers based off of PointRight report and assured proper interventions are in place. E. Braden assessment shall be completed upon admission and quarterly for all residents. F. Beginning 2/5/18 a tissue tolerance assessment shall be completed upon admission and quarterly for all residents. 26 have been completed including those residents with a current pressure ulcer. G. A skin assessment was completed on all current residents to assure all skin issues are accounted for, documented, treated and tracked. H. A new weekly skin assessment has been implemented. The new skin assessment has a whole body, front and back diagram and addresses surface pressure. Recurrence will be prevented by: A. All Staff were educated on the 'Prevention of Pressure Ulcers' policy.	

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

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{F 314}	Continued From page 7 designed to completely surround the foot, heel and calf, insulating and protecting the healing limb and preventing pressure ulcers) on the left lower extremity at all times. The care plan also identified R6 had a pressure relieving foam cushion on wheelchair, and a high density pressure relieving mattress on the bed, and directed staff to provide wound care as ordered. The nursing assistant (NA) assignment sheet updated 1/12/18, directed to keep pressure off of R6's coccyx, keep pressure off of his heel/achilles, and protect and avoid any trauma to his left foot. The NA assignment sheet also directed to encourage R6 to get up in the chair throughout the day, no foot wear, and wear the Rooke boot at all times. The assignment sheet also directed to toilet and reposition R6 every two hours. The assignment sheet also indicated it was okay to leave the Hoyer (mechanical lift) sling in the wheelchair due to discomfort. On 1/17/18, at 7:45 a.m. R6 was continuously observed. R6 was up in the wheelchair sitting near the nursing desk. R6 had a foam cushion in his wheelchair. R6 was dressed, and had the Rooke boot on his left foot. At 8:20 a.m. R6 went to the dining room for breakfast. At 8:44 a.m. R6 exited the dining room with staff, and was brought back to his room. At 8:50 a.m. two staff entered the room with the Hoyer lift and put R6 on the bed. At 8:55 a.m. an application of a new dressing was observed with licensed practical nurse (LPN)-B. R6 had a pressure ulcer to the left of the coccyx, approximately 1 centimeter (cm) round, and appeared to be a Stage 2. LPN-B stated the pressure ulcer was healed on Monday (1/15/18). A new foam border dressing was applied to R6's coccyx and the pressure ulcer on	{F 314}	B. Wound nurse performs weekly skin assessments on residents with a current pressure ulcer. Other nurse managers serving as back up in the absence of the wound nurse. C. Facility will perform repositioning tagging audits at least six times per week for one month, then three times per week for three months to assure residents are repositioned per the plan of care. Audits will be completed on all shifts and units. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. D. Facility will perform audits three times per week for four months to assure weekly skin assessments are completed. Audits will be completed on all units. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. E. Facility will perform compliance audits for proper interventions in place six times per week for four weeks, then three times per week for three months. Audits will be completed on all shifts and units. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R-C 01/19/2018

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

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{F 314}	Continued From page 8	{F 314}		

the left side of the coccyx. LPN-B then removed a soiled dressing from the back of R6's right thigh. This area was pink and appeared healed. LPN-B cleansed the area and applied a new dressing. LPN-B stated they kept a dressing on this healed pressure ulcer for protection.

On 1/18/18, at 6:40 a.m. R6's coccyx pressure ulcer was observed with registered nurse (RN)-A. RN-A stated the pressure ulcer on the left side of R6's coccyx was new yesterday. The pressure ulcer measured 1.1 cm x 1.0 cm with pink edges. The skin surrounding the pressure ulcer was blanchable. RN-A stated the pressure ulcer was a Stage 2 and the slit on the center of R6's coccyx measured 1.3 cm and she could barely see it.

Review of R6's Weekly Skin Assessments revealed the following:

On 12/18/17, the assessment indicated R6's skin was intact and unbroken, and a barrier cream was applied to the buttocks for prevention.

On 1/8/18, the assessment indicated R6 had no new skin issues identified since the previous week, but noted his skin was not intact. The skin assessment directed to describe the skin condition with it's corresponding location. The assessment lacked the location and description of the skin issues, indicating only a foam border to the coccyx and the right back inner thigh area. The assessment also indicated the thigh area was healing well.

On 1/15/18,the assessment indicated R6's skin was intact/unbroken, and there were no new skin issues identified from the previous week. The skin assessment directed to describe the skin

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{F 314}	Continued From page 9	{F 314}		

condition with a location and description. The assessment lacked the locations and descriptions. The assessment indicated a foam border dressing to the to the coccyx for protection, and the coccyx had healed well, and a pink area remained. The assessment also indicated a foam border dressing was applied to the right upper gluteal fold for protection, and that area had healed well.

No further Weekly Skin Assessments were provided by the facility.

Review of R6's progress notes revealed the following:

On 12/4/17, the note indicated R6 was up as usual, used a Hoyer for transfers, needed the assistance of two staff with cares and denied pain. R6 was incontinent of bowel and bladder. R6 had a Mepilex (a foam dressing) dressing in place on the coccyx and was to be turned every two hours while in bed. The note lacked any further description of why a dressing was placed on R6's coccyx.

On 12/18/17, the note indicated staff had attempted to change R6's coccyx wound dressing twice, but he refused. The note lacked any further description of R6's coccyx wound.

On 1/2/18, at 8:48 a.m. the note included a Skin Issue report. The report indicated a "cut" in the center crease of R6's buttocks. The cut measured 2.1 cm in length, and was red in color. The area was cleansed with normal saline and a foam border dressing was applied for protection. The report also indicated R6 had a blanchable open area on his right upper thigh. The open area

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{F 314}	Continued From page 10	{F 314}		

was missing the top layer of skin, the wound bed was pink, and the area measured 1.5 cm by 0.7 cm. The RN taught R6 about the importance of offloading (removing pressure to an area for a period of time) and repositioning at least every two hours due to his refusals in the past. R6 stated he understood. The assessment lacked further assessment of the areas, new interventions to prevent further deterioration and to promote healing of the areas, and assessment of the surfaces R6 sat and laid on, to determine the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects.

On 1/3/18, the note indicated the areas of R6's right upper thigh and the crease of the buttocks were cleansed and a foam border dressing was applied. The note lacked assessment of the areas.

On 1/4/18, the note indicated an order to cleanse the right back thigh wound with normal saline and cover with a foam border dressing, and change the dressing every two days and as needed. The note lacked assessment of the areas.

On 1/9/18, the note indicated a Braden Scale (for predicting pressure ulcer risk) was completed. The Braden Scale indicated R6 was at moderate risk for pressure ulcers. The Braden Scale lacked any further assessment of R6's skin.

On 1/11/18, the note indicated R6 had a history of type 2 diabetes and pressure ulcers. The note indicated R6 had a right back thigh wound that measured 1.0 cm by 0.9 cm, and was pink with the epidermis (outer layer of skin) rubbed off and a scant amount of serosanguineous drainage

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{F 314}	Continued From page 11	{F 314}		

(yellow drainage with a small amount of blood) was present. A foam border for protection was to be changed every two days. No other skin issues were noted.

On 1/13/18, the note indicated R6 had a coccyx wound, and apply Mepiplex (foam border dressing) and change daily.

On 1/15/18, the note indicated R6 had a history of diabetes and pressure ulcers. The note further indicated R6 had a right back thigh wound that had healed, and a foam border dressing remained for protection.

The Interdisciplinary Team (IDT) Wound Minutes dated 1/11/18, reiterated the progress note of 1/11/18. The minutes indicated R6 had a history of type 2 diabetes and pressure ulcers. The minutes also indicated R6 had a right back thigh wound that measured 1.0 cm by 0.9 cm, was pink where the epidermis had rubbed off, and a scant amount of serosanguineous drainage was present. A foam border for protection was to be changed every two days. No other skin issues were noted.

On 1/12/18, a Therapy Screening Form was completed due due to a fall R6 sustained on 1/11/18. The form indicated areas that reflected a change in condition or an area with a deficit that may warrant therapy included difficulty with mobility (wheelchair mobility), poor positioning/body alignment, and fall risk. The form also indicated "Other" and a handwritten note indicated "Resident slid out of chair, would benefit from better positioning/cushion." The form recommended Occupational Therapy (OT) to evaluate and treat, as well as obtain a

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{F 314}	Continued From page 12	{F 314}		

prescription for a custom wheelchair with custom seating. The form lacked any indication of R6's history of pressure ulcers and/or obtaining a pressure relieving wheelchair cushion.

On 1/16/18, at 4:10 p.m. R6 was observed sitting up in his wheelchair with the Rooke boot on.

A Skin Issue report dated 1/17/18, indicated R6 had a Stage 2 pressure ulcer to the left buttocks that measured 1.0 cm by 0.9 cm and less than 0.2 cm deep. A scant amount of serosanguineous drainage was present. The pressure ulcer had pink edges, had 70% slough, and 30% pink epithelial tissue. The skin surrounding the pressure ulcer was purple and blanchable. The pressure ulcer was cleansed and a foam border dressing was applied. The progress note indicated R6 also had a 1.4 cm cut to the center of the buttocks, with a small amount of serosanguineous drainage. The area was cleansed and a barrier cream was applied. R6's family and physician were notified. The assessment lacked further assessment of the areas, new interventions to prevent further deterioration and to promote healing of the areas, and assessment of the surfaces R6 sat and laid on, to determine the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects.

On 1/17/18, at 2:17 p.m. RN-A was interviewed and stated she was the nurse responsible for monitoring resident pressure ulcers. RN-A stated R6 had a history of pressure ulcers that would develop and then heal. RN-A stated last week R6's coccyx had a tiny area where the skin had rubbed off. RN-A stated she was off work the first week of January, and returned to work 1/8/18.

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{F 314}	Continued From page 13	{F 314}		

RN-A stated she had observed R6's skin on 1/11/18, and the area on the back of R6's thigh measured 1.0 x 0.9, but R6's coccyx was clear. RN-A was asked if the pressure ulcer to the left of the coccyx was present between 1/3/18, and 1/9/18. RN-A stated it was classified as a shearing injury, not a pressure ulcer. RN-A further stated R6 was at risk for pressure ulcers due to diseases of arteries, capillaries, diabetes and limited mobility. RN-A stated she was not a certified wound nurse, but received on the job training.

On 11/18/18, at 6:55 a.m. LPN-B stated R6 usually got up about now, and would go to the dining room for breakfast. LPN-A stated after breakfast the NAs lay R6 down to change him, then get him back into his wheelchair.

On 1/18/18, at 7:55 a.m. the therapy director (TD) stated R6 had a fall on 1/11/18, and therapy had done a screening on 1/12/18. They were now waiting for the OT evaluation for a new wheelchair to be signed. The TD stated R6 would benefit from a better positioning cushion, and a new custom chair. The TD further stated a pressure redistribution cushion would help R6, as his current wheelchair cushion was just a regular foam cushion.

On 1/18/18, at 8:09 a.m. NA-H stated R6 was usually one of the first residents up in the morning. NA-H stated she usually worked the on the unit where R6 resided. NA-H stated they usually try to check and change R6 before lunch, but sometimes they do not have time because they are so busy. NA-H stated this past Saturday, R6 did lay down to be checked and changed before lunch, but on Sunday R6 did not lay down

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{F 314}	Continued From page 14	{F 314}		

to be checked and changed before lunch because it was too busy, and staff did not have time. NA-H stated R6 did was not toileted or repositioned until after lunch on Sunday. NA-H further stated they try to provide cares timely to R6 because they are aware of the pressure ulcer on his coccyx.

On 1/18/18, at 9:28 a.m. the occupational therapist (OT) was present in R6's room. The OT stated he had changed just R6's wheelchair cushion to a ROHO cushion (a cushion with air filled chambers, redistributing pressure). The previous wheelchair cushion remained in the room and was observed with the OT. The OT stated the previous wheelchair cushion was a foam cushion, and did not provide pressure reduction or pressure relief.

On 1/18/18, at 9:42 a.m. LPN-B stated 1/2/18, was when the pressure ulcer to the left of the coccyx was first noticed. LPN-B stated the pressure ulcer was pinpoint size. LPN-B stated on 1/12/18, the pressure ulcer was still there, and on 1/13, and 1/14, it looked to be improving. LPN-B stated the pressure ulcer was almost healed on 1/15/18. LPN-B stated when she saw the pressure ulcer on 1/17/18, it had no dressing and looked worse.

On 1/18/18, at 9:49 a.m. R6 was interviewed. R6 stated he would rather lay on the bed than sit in the wheelchair because, "I'm not going any place." R6 stated, "I spend a lot of time in the chair, I don't like to be in it. It's not the most comfortable, it makes my butt hurt. I've had the new kind of cushion [the ROHO] before, it's crap." R6 was asked if he ever refused to get up or lay down. R6 stated, "I just do what they ask or tell

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

me to do." R6 stated he had a sore on his coccyx, stating, "It doesn't hurt now, it hurts when I'm up in the chair."

On 1/18/18, at 10:00 a.m. the director of nursing (DON), the assistant director of nursing (ADON), and RN-B were present during an interview. The DON stated they believed the pressure ulcer developed between 1/16/18, and 1/17/18, as the Weekly Skin Assessment done on 1/15/18, did not indicate a pressure ulcer. The DON stated skin assessments were done weekly and quarterly with the MDS. The DON further stated a Braden Scale was completed, the care plan was reviewed and updated, and interventions were added if the resident had open areas. RN-B verified R6's current care plan interventions were reviewed and were appropriate. The DON verified the only assessments done were the Braden Scale, and R6's medical record lacked a narrative documentation or a summary of the Braden Scale. The DON also verified there was no assessment of the surfaces R6 sat or laid on to determine the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects. The DON stated the facility used the weekly skin assessments to identify skin issues, and had weekly wound IDT meetings, and RN-A recorded the minutes during the weekly wound IDT meetings.

The facility's Prevention of Pressure Ulcers policy dated 12/17/17, indicated the purpose of the policy was to provide information regarding identification of pressure ulcer risk, and interventions for specific risk factors. The policy's interventions and preventative measures directed for a resident in bed change position at least

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{F 314}	Continued From page 16 every two hours and more frequently if needed. If a resident used a chair, change position at least every hour, and use a foam, gel or air cushion as indicated to relieve pressure. The policy further directed the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, and addressed.	{F 314}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PZHW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00589

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

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

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

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

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

6. DATE OF SURVEY **11/17/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **139** (L18)
13.Total Certified Beds **139** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR-SWS 01/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 01/05/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

On October 19, 2017, an abbreviated standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of J. At the time of the abbreviated standard survey, conditions in the facility constituted immediate jeopardy (IJ) to resident health or safety. The Immediate Jeopardy began on 8/31/2017. The Admin/DON were notified of the IJ on 9/14/17, at 4:45 p.m. The IJ was removed on 9/19/2017, at 4:20 p.m. Non-compliance remained at the lower scope and severity level of actual harm. Previous results identified AEM Case MNSJQ4 with abbreviated surveys 10/23/2015, cited "G" at F333; Extended survey of November 18, 2015 cited "G" at F309 and "J" at F323.

On November 17, 2017, the Departments of Health and Public Safety completed a standard survey at this facility. The most serious deficiencies were cited at a S/S level of F. The facility remains in non-compliance. Investigation of complaint H227075 was completed and substantiated at F225 and F226.

Electronically delivered
December 7, 2017

Mr. David Uselman, Administrator
Bayshore Residence & Rehabilitation Center
1601 St. Louis Avenue
Duluth, MN 55802

RE: Project Numbers S5227028, H5227072, H5277075

Dear Mr. Uselman:

On November 14, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 19, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F441. (42 CFR 488.430 through 488.444).

This was based on deficiencies found during an abbreviated standard survey completed on October 19, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On November 17, 2017, the Minnesota Department of Health and Department of Public Safety completed a standard recertification survey. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required. In addition, at the time of the standard survey completed November 17, 2017, an investigated complaint number H5227075 was conducted and found to be substantiated at F225 and F226.

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

In addition, this Department recommended to the CMS Region V Office the following action:

- Civil money penalty for deficiency cited at F441, be imposed. (42 CFR 488.430 through 488.444)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 19, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 19, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 19, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bayshore Residence & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 19, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
E-mail: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include electronic acknowledgement signature of provider and date.

The state agency may, in lieu of a 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:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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, Office of Health Facility Complaints staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 19, 2018 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
E-mail: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	C 11/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. Investigation of complaint H5227075 was completed and substantiated. Deficiencies issued at F225 and F226. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 157		1/9/18

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

Electronically Signed | 12/17/2017

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F 157	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the resident representative was notified of x-ray results and a new antibiotic	F 157	F 157- D Corrective Action: A. The Facility notified R15□s Family	

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F 157	Continued From page 2 for 1 of 1 residents (R15) reviewed for notification of change. Findings include: R15's Diagnosis Report dated 11/16/17, indicated R15's diagnoses included chronic obstructive pulmonary disease and emphysema. R15's Face Sheet printed 11/16/17, indicated family representative (FR)-A was the power of attorney, the decision maker, and the emergency contact. The Authorizations and Acknowledgements form (not dated) signed by FR-A indicated FR-A was to be notified with changes in condition, which included a change in R15's physical status. R15's admission Minimum Data Set (MDS) dated 8/28/17, indicated R15 required extensive assistance from staff with bed mobility, transfers, toilet use, and personal hygiene. The MDS also indicated R15 required limited assistance of staff with walking and dressing. R15's care plan dated 10/17/17, directed staff to communicate with R15's family regarding R15's capabilities or needs. The Physician Order sheet dated and signed on 10/18/17, indicated the physician ordered a chest x-ray and Augmentin (an antibiotic) 875 milligrams (mg) twice a day for 10 days. The progress notes dated 10/18/17, through 10/30/17, indicated the following: On 10/18/17, R15 had a condition change with a cough, the physician assessed R15 and ordered blood work, and a chest x-ray. R15 also was started on an antibiotic and nebulizer treatments.	F 157	Representative of the x-ray results. B. Facility Antibiotic tracking form reviewed and updated to include a space to document Responsible Party notification. Corrective Actions as it applies to other Residents: A. The □Change in Residents Condition or Status□ policy was reviewed and dated. B. LPN□s and RN□s were re-educated on the □Change in Residents Condition or Status□ policy. The re-education occurred in small group and 1:1 meetings lead by the Director of Nursing or Assistant Director of Nursing. C. All Staff educated on findings of F157 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. D. Facility will review resident records from 11/15/2017 to current to assure responsible parties were notified of new medications, x-ray results, or a change in the Residents condition or status. Date of Completion: January 9, 2017 Recurrence will be prevented by: A. Facility will perform audits of resident records to assure proper notifications are being made. Audits will occur 4x□s per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI	

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F 157	Continued From page 3 On 10/19/17, at 4:09 a.m. R15 continued on the antibiotic for possible pneumonia with no side effects. On 10/19/17, at 8:39 a.m. a telephone call was made and a message was left for FR-A in regards to a condition change. The progress note lacked evidence of notification of the antibiotic, and the results of the chest x-ray. On 11/13/17, at 6:29 p.m. FR-A was interviewed and stated she was told R15 was having an x-ray and R15 may have pneumonia, but was not informed of the the final results. FR-A stated she had heard later R15 was on an antibiotic for pneumonia. On 11/15/17, at 1:32 p.m. FR-A was interviewed and stated she was not informed of the x-ray results or of the antibiotic. If FR-A would have known R15 had pneumonia, she would have made sure she was with R15, and FR-A assumed R15 did not have pneumonia. FR-A further stated she was told this morning during the care conference that they did not think R15 had pneumonia, but treated her with an antibiotic anyway. FR-A stated she would have liked to have had the chance to offer more support to R15. FR-A stated she visits R15 two to three days a week for a couple of hours each time. On 11/16/17, at 11:18 a.m. registered nurse (RN)-D verified the progress note did not indicate family notification of the chest x-ray results or the use of the antibiotic. RN-D further stated the family should be notified anytime there was a change in the resident's condition, and when a new medication was started.	F 157	Committee will determine when the audits may be discontinued. B. On the spot re-education will be made if audit findings demonstrate a failure to make notifications to responsible party. Responsible Person: Director of Nursing	

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F 157	Continued From page 4 On 11/16/17, at 1:38 p.m. the director of nursing (DON) stated she would expect the family to be notified of x-ray results, condition changes, and medication changes, including antibiotics, within 24 hours. The facility's Change in a Resident's Condition or Status policy undated, directed unless otherwise instructed by the resident, the nurse supervisor or charge nurse would notify the resident's family or representative when there was a significant change in the resident's physical, mental, or psychosocial status within 24 hours of a change occurring in the resident's medical or mental condition or status.	F 157		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70	F 164		1/15/18

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F 164	Continued From page 5 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy was maintained during blood glucose monitoring, and insulin administration for 3 of 4 residents (R20, R13, R90) observed during blood glucose monitoring and insulin administration. Findings include: R20's Admission Record printed 11/14/17, indicated R20's diagnoses included diabetes. R20's quarterly Minimum Data Set (MDS) dated 8/14/17, indicated R20 was cognitively intact.	F 164	F 164- D Corrective Action: A. All LPN's, RN's and TMA's were educated on proper privacy and dignity practices when providing diabetic cares. B. Facility ordered blood glucose testing machines for each resident. Each machine will be stored in the Residents room to promote privacy and dignity when providing diabetic cares. Corrective Actions as it applies to other Residents: A. All Staff educated on findings of F164	

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F 164	Continued From page 6 R13's Admission Record printed 11/14/17, indicated R13's diagnoses included diabetes. R13's quarterly MDS dated 9/5/17, indicated R13 had moderately impaired cognition. R90's Admission Record printed 11/14/17, indicated R90's diagnoses included diabetes. R90's quarterly MDS dated 8/14/17, indicated R90 was cognitively intact. On 11/13/17, the following was observed: At 4:07 p.m. licensed practical nurse (LPN)-A was observed doing a blood glucose check in front of the nursing desk on R20. R20 had two other residents sitting next to her, and four other residents were approximately 15 feet away. At 4:28 p.m. trained medication aide (TMA)-A approached R13 in the sitting area near the nursing desk. TMA-A performed a blood glucose check on R13, then stated the results out loud. One resident was sitting next to R13, and three other residents were approximately 15 feet away. At 4:31 p.m. TMA-A approached R90 in the sitting area near the nursing desk. TMA-A performed a blood glucose check on R90, then stated the results out loud across the room to LPN-A. One resident was sitting next to R90, and three other residents were approximately 15 feet away. At 4:45 p.m. LPN-A approached R90 in the sitting area near the nursing desk. R90 lifted his shirt exposing his stomach and LPN-A injected insulin into R90's right abdomen. One resident was sitting next to R90, and three other residents	F 164	and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. Date of Completion: January 15, 2017 Recurrence will be prevented by: A. Facility will perform audits three times per day, 4x's per week for 2 weeks, then 3x's per week audits for 4 weeks, then weekly audits for 3 months. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

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F 164	Continued From page 7	F 164		

were approximately 15 feet away.

At 4:58 p.m. LPN-A lifted R13's shirt exposing the stomach area and injected insulin into R13's left abdomen. One resident was sitting next to R13, and three other residents were approximately 15 feet away.

On 11/13/17, at 6:27 p.m. LPN-A verified she checked R20's blood glucose and gave R13 and R90 their insulin in the public area. LPN-A stated she had worked at the facility for four years, and had always done it this way. LPN-A further stated the residents had never complained about having these treatments done in public. LPN-A verified she did not ask the residents if it was okay to do these treatments in public.

On 11/13/17, at 7:12 p.m. TMA-A verified she checked R13 and R90's blood glucose in the public area, and stated that was what she usually did. TMA-A further stated she did not ask the resident if it was okay to do this in public, and stated she did not ask other residents in the area if it bothered them. TMA-A verified she stated the blood glucose results out loud, and she should not have.

On 11/14/17, at 3:30 p.m. the director of nursing (DON) stated staff should not be doing blood glucose checks and/or giving insulin in a public area. The DON also stated staff should not be stating the results of the blood glucose checks out loud. The DON would expect staff to take residents to their rooms for blood glucose checks and/or insulin administration.

The facility's Obtaining a Fingerstick Glucose Level and the Insulin Administration policies (both

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F 164	Continued From page 8 undated) lacked direction on taking the residents to a private area for these treatments.	F 164		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and	F 225		1/15/18

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

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F 225	Continued From page 9 misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to report to the State Agency suspected abuse for 2 of 3 residents (R57, R89) whose incidents were reviewed. In addition, the facility failed to ensure internal investigations were completed and reported to the State Agency within 5 days for 3 of 4 residents (R107, R55, R129) whose internal investigations were reviewed.	F 225	F 225- D Corrective Action: A. Facility educated the staff responsible for submitting the final reports (Social Worker, Director of Social Services, Director of Nursing and Administrator) of the regulation that final reports are to be submitted within five days.	

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F 225	Continued From page 10 Findings include: R57's annual Minimum Data Set (MDS) dated 10/2/17, indicated R57 had diagnoses that included Alzheimer's disease and dementia.The MDS also indicated R57 had severely impaired cognition, and required assistance with ADLs. R89's quarterly MDS dated 8/9/17, indicated R89 had diagnoses that included bipolar disorder and psychotic disorder. The MDS further indicated R89 had moderately impaired cognition, did not ambulate, and required extensive assistance with activities of daily living (ADLs). R94's admission MDS dated 8/26/17, indicated R94 had diagnoses that included Alzheimer's disease, dementia, anxiety, depression and aphasia (difficulty speaking). The MDS further indicated R94 had severely impaired cognition and was independent or required only supervision for many activities of daily living (ADLs). A facility incident report dated 8/24/17, indicated R94 took hold of R57's shoulders. R94's 8/24/17, progress note indicated R94 grabbed R57's shoulders, forcefully shaking/pushing R57 to the point where R57 started to lose her balance. The two residents were separated by and no injuries occurred. A facility incident report dated 10/25/17, indicated R94 was yelling and arguing with R89, and R94 grabbed R89 by the arm. On 11/16/17, at 11:14 a.m. social worker (SW)-A was interviewed and stated that no report was made to the State Agency (SA) for the for the	F 225	Corrective Actions as it applies to other Residents: A. All Staff educated on findings of F225 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. Date of Completion: January 15, 2017 Recurrence will be prevented by: A. Facility will perform audits weekly for 3 months to assure final reports are submitted timely. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Administrator	

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F 225	Continued From page 11	F 225		

8/24/17, and the 10/25/17, incidents because the resident's exhibited, "No distress, no injury." The SW further stated there was no injury, and the staff intervened and ensured resident safety.

Review of facility reports to the SA revealed the following incidents:

On 6/15/17, R55 reported a nursing assistant (NA) was gruff with her. R55 reported the NA took R55's fist, placed it against R55's head above her temple area, and pushed her just slightly with her fist. R55 reported being afraid of the NA. The incident was reported to the SA on 6/15/17, at 3:05 p.m. An investigation was conducted, but was not reported to the SA until 7/26/17, at 3:08 p.m.

On 9/8/17, R94 was poked in the back by R107. R94 in turn punched R107 repeatedly in the face several times before staff could intervene and separate the two residents. R107 sustained abrasions and bruising by his right eye. R94 was sent to the hospital and subsequently to a behavioral health unit for medication adjustments. The incident was immediately reported to the SA. An investigation was conducted, but was not reported to the SA until 9/19/17, at 3:52 p.m.

On 9/13/17, at approximately 5:00 p.m., a facility nurse and nursing assistant heard an altercation and found R107 on the floor, and R94 standing over R107; both residents were wrestling for control of R107's walker. The residents were separated and assessed to have no injury. R107 stated R94 told him to, "Go home." The incident was immediately reported to the SA. An investigation was conducted, but was not submitted to the SA until 10/21/17, at 1:40 p.m.

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F 225	Continued From page 12 On 10/4/17, staff heard residents yelling in the hallway. Staff immediately responded and found R129 on the floor and R94 nearby. Camera review revealed R94 attempting to enter R129's room and a subsequent tug of war with R129's door, resulting in R129 landing on the floor. This incident was reported to the SA on 10/4/17, at 6:14 p.m. An investigation was conducted, but was not submitted to the SA until 10/21/17, at 2:38 p.m. On 11/16/17, at 11:14 a.m. social worker (SW)-A was interviewed and confirmed the above incidents. SW-A stated investigation reports were to be submitted to the SA within 5 days. SW-A stated she did not know what the facility policy stated, but knew that was the regulation. On 6/15/17, a resident reported staff treatment that was suspected abuse. The incident was immediately reported to the SA on 6/15/17. The investigation report was not submitted until 7/26/17. On 11/16/17, at 11:14 a.m. SW-A stated this was not timely. On 9/8/17, a resident to resident incident occurred between R94 and R107. This incident was immediately reported to the SA, but the investigation report was not submitted until 9/19/17. On 11/16/17, at 11:14 a.m. SW-A confirmed the dates and the late submission. On 9/13/17, a resident to resident incident occurred between R94 and R107. The incident was immediately reported to the State Agency (SA), but the investigation report was not submitted until 10/21/17. On 11/16/17, at 11:14 a.m. SW-A confirmed the investigation was	F 225		

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F 225	Continued From page 13	F 225		

submitted late.

On 10/4/17, a resident to resident incident occurred between R94 and R129. The incident was immediately reported to the SA. On 11/16/17, at 11:14 a.m. SW-A confirmed the investigation was not submitted to the SA until 10/21/17.

On 11/17/17, at 9:17 a.m. the administrator was interviewed and stated the facility was very good with immediate reporting to the SA. The administrator stated the late investigations were mostly due to SW-C who no longer worked at the facility. The administrator stated incidents on 8/24/17, and 10/25/17, involving R94 and other residents were not reported to the SA because of R94's limited cognition and R94 didn't know what he was doing.

The facility's Abuse Prohibition Plan, revised 2/28/17, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy indicated a reportable incident was a resident to resident altercation in which there is intent to harm. A resident to resident altercation decision tool included in the facility policy indicated even though a resident may have a cognitive impairment, he/she could still commit a willful act. The policy directed staff to immediately report suspected maltreatment either internally (to the administrator, social service director or director of nursing), or externally to the SA. The policy continued to describe the steps necessary to complete an internal investigation, including completion of a thorough internal investigation to the SA within 5 business days.

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F 226	Continued From page 14	F 226		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to implement their abuse prohibition	F 226	F 226- D Corrective Action:	1/15/18

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F 226	Continued From page 15 policy which required immediate notification to the State Agency for allegations of abuse for 2 of 3 residents (R57, R89) whose incident reports were reviewed. In addition, the facility failed to implement their abuse prohibition policy which required internal investigations to be completed and reported to the State Agency within 5 days for 3 of 4 residents (R107, R55, R129) whose internal investigations were reviewed. Findings include: The facility's Abuse Prohibition Plan, revised 2/28/17, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy indicated a reportable incident was a resident to resident altercation in which there is intent to harm. A resident to resident altercation decision tool included in the facility policy indicated even though a resident may have a cognitive impairment, he/she could still commit a willful act. The policy directed staff to immediately report suspected maltreatment either internally (to the administrator, social service director or director of nursing), or externally to the SA. The policy continued to describe the steps necessary to complete an internal investigation, including completion of a thorough internal investigation to the SA within 5 business days. R57's annual Minimum Data Set (MDS) dated 10/2/17, indicated R57 had diagnoses that included Alzheimer's disease and dementia.The MDS also indicated R57 had severely impaired cognition, and required assistance with ADLs. R89's quarterly MDS dated 8/9/17, indicated R89	F 226	A. Facility educated the staff responsible for submitting the final reports (Social Worker, Director of Social Services, Director of Nursing and Administrator) of the regulation that final reports are to be submitted within five days. Corrective Actions as it applies to other Residents: A. All Staff educated on findings of F164 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. Date of Completion: January 15, 2017 Recurrence will be prevented by: A. Facility will perform audits weekly for 3 months to assure final reports are submitted timely. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Administrator	

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F 226	Continued From page 16	F 226		

had diagnoses that included bipolar disorder and psychotic disorder. The MDS further indicated R89 had moderately impaired cognition, did not ambulate, and required extensive assistance with activities of daily living (ADLs).

R94's admission MDS dated 8/26/17, indicated R94 had diagnoses that included Alzheimer's disease, dementia, anxiety, depression and aphasia (difficulty speaking). The MDS further indicated R94 had severely impaired cognition and was independent or required only supervision for many activities of daily living (ADLs).

A facility incident report dated 8/24/17, indicated R94 took hold of R57's shoulders. R94's 8/24/17, progress note indicated R94 grabbed R57's shoulders, forcefully shaking/pushing R57 to the point where R57 started to lose her balance. The two residents were separated by and no injuries occurred.

A facility incident report dated 10/25/17, indicated R94 was yelling and arguing with R89, and R94 grabbed R89 by the arm.

On 11/16/17, at 11:14 a.m. social worker (SW)-A was interviewed and stated that no report was made to the State Agency (SA) for the for the 8/24/17, and the 10/25/17, incidents because the resident's exhibited, "No distress, no injury." The SW further stated there was no injury, and the staff intervened and ensured resident safety.

Review of facility reports to the SA revealed the following incidents:

On 6/15/17, R55 reported a nursing assistant (NA) was gruff with her. R55 reported the NA took

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F 226	Continued From page 17	F 226		

R55's fist, placed it against R55's head above her temple area, and pushed her just slightly with her fist. R55 reported being afraid of the NA. The incident was reported to the SA on 6/15/17, at 3:05 p.m. An investigation was conducted, but was not reported to the SA until 7/26/17, at 3:08 p.m.

On 9/8/17, R94 was poked in the back by R107. R94 in turn punched R107 repeatedly in the face several times before staff could intervene and separate the two residents. R107 sustained abrasions and bruising by his right eye. R94 was sent to the hospital and subsequently to a behavioral health unit for medication adjustments. The incident was reported to the SA on need date. An investigation was conducted, but was not reported to the SA until 9/19/17, at 3:52 p.m.

On 9/13/17, at approximately 5:00 p.m., a facility nurse and nursing assistant heard an altercation and found R107 on the floor, and R94 standing over R107; both residents were wrestling for control of R107's walker. The residents were separated and assessed to have no injury. R107 stated R94 told him to, "Go home." The incident was reported to the SA on need date. An investigation was conducted, but was not submitted to the SA until 10/21/17, at 1:40 p.m.

On 10/4/17, staff heard residents yelling in the hallway. Staff immediately responded and found R129 on the floor and R94 nearby. Camera review revealed R94 attempting to enter R129's room and a subsequent tug of war with R129's door, resulting in R129 landing on the floor. This incident was reported to the SA on 10/4/17, at 6:14 p.m. An investigation was conducted, but was not submitted to the SA until 10/21/17, at

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F 226	Continued From page 18 2:38 p.m. On 11/16/17, at 11:14 a.m. social worker (SW)-A was interviewed and confirmed the above incidents. SW-A stated investigation reports were to be submitted to the SA within 5 days. SW-A stated she did not know what the facility policy stated, but knew that was the regulation. On 6/15/17, a resident reported staff treatment that was suspected abuse. The incident was immediately reported to the SA on 6/15/17. The investigation report was not submitted until 7/26/17. On 11/16/17, at 11:14 a.m. SW-A stated this was not timely. On 9/8/17, a resident to resident incident occurred between R94 and R107. This incident was immediately reported to the SA, but the investigation report was not submitted until 9/19/17. On 11/16/17, at 11:14 a.m. SW-A confirmed the dates and the late submission. On 9/13/17, a resident to resident incident occurred between R94 and R107. The incident was immediately reported to the State Agency (SA), but the investigation report was not submitted until 10/21/17. On 11/16/17, at 11:14 a.m. SW-A confirmed the investigation was submitted late. On 10/4/17, a resident to resident incident occurred between R94 and R129. The incident was immediately reported to the SA on need date and time On 11/16/17, at 11:14 a.m. SW-A confirmed the investigation was not submitted to the SA until 10/21/17. On 11/17/17, at 9:17 a.m. the administrator was	F 226		

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F 226	Continued From page 19 interviewed and stated the facility was very good with immediate reporting to the SA. The administrator stated the late investigations were mostly due to an employee who no longer worked at the facility. The administrator stated incidents on 8/24/17, and 10/25/17, involving R94 and other residents were not reported to the SA because of R94's limited cognition and R94 didn't know what he was doing.	F 226		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a dignified dining experience was provided for 2 of 3 residents (R2, R4) observed during meals. Findings include: R2's Admission Record printed 11/16/17, indicated R2's diagnoses included dementia and quadriplegia. R2's quarterly Minimum Data Set (MDS) dated 8/21/17, indicated R2 had moderately impaired cognition, and required extensive assistance from staff with eating. R4's Admission Record printed 11/15/17, indicated R4's diagnoses included multiple sclerosis, and paraplegia. R4's quarterly MDS dated 10/16/17, indicated R4 had moderately	F 241	F 241-D Corrective Action: A. NA-D was counseled on providing proper dignity to Residents during their meals. NA-D is no longer employed by the Facility. Corrective Actions as it applies to other Residents: A. All Staff were educated on the 'Dignity During Dining', 'Assistance with Meals' policy; specifically, that staff should be seated when assisting with meals. Education was provided in three large group meetings, several small group meetings and 1:1 education. B. Created new policy for dignity during dining observations.	1/15/18

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F 241	Continued From page 20 impaired cognition, and required supervision with eating. On 11/13/17, at approximately 5:45 p.m. during the supper meal in the Park Breeze dining room, nursing assistant (NA)-D was observed standing between R2 and R4, assisting both R2 and R4 with eating through the entire meal. Licensed practical nurse (LPN)-A was also sitting at the same table assisting another resident with eating. When R2 was finished eating, NA-D pushed R2 out of the dining room in the wheelchair. On 11/13/17, at 6:06 p.m. NA-D was interviewed and stated she usually stood while assisting residents with eating because it was more comfortable and stated, "When you're sitting, it's a long reach." On 11/15/17, at 2:39 p.m. the director of nursing (DON) stated she would expect staff to be seated when assisting residents with eating. The facility's Assistance with Meals policy undated, indicated residents who could not feed themselves would be fed with attention to safety, comfort and dignity. This included not standing over the residents while assisting them with meals.	F 241	Date of Completion: January 15, 2017 Recurrence will be prevented by: A. Facility will perform dignity audits twice per day 4x's per week for 2 weeks, then audits 4x's per week for 4 weeks, then weekly audits for 3 months. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate	F 278		1/9/18

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F 278	Continued From page 21 each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 1 of 3 residents (R103) reviewed for dental services. Findings include: R103's Diagnosis Report printed 11/16/17, indicated R103's diagnoses included dementia	F 278	F 278-D Corrective Action: A. The mistake in R103 MDS has been corrected to match the care plan, assessment and residents actual condition. Corrective Actions as it applies to other Residents:	

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F 278	Continued From page 22 and aphasia (a language impairment commonly from a stroke). R103's annual Minimum Data Set (MDS) dated 10/24/17, indicated R103 had no natural teeth or tooth fragments and was edentulous (without teeth). R103's care plan dated 8/11/17, indicated R103 had a lower denture and an upper partial. The partial needed to be removed at night and placed in a denture cup with water. R103's dental Care Area Assessment (CAA) dated 10/23/17, indicated R103 had a full set of dentures, and staff provided all denture care due to R103's dementia. Staff removed and replaced R103's dentures daily. On 11/15/17, at 12:15 p.m. R103 was observed at lunch. R103 was missing a tooth on the upper right side of the front tooth. R103 did not have any other teeth missing and they all appeared to be her own teeth. On 11/15/17, at 12:50 p.m. nursing assistant (NA)-B stated R103 had a lower partial, and she would assist with placement of the partial after R103 brushed her own teeth. NA-B stated staff would set up toothbrush and toothpaste for R103 in the morning so she would brush her teeth independently, and during the rest of the day R103 will go into her room and get the supplies out and brush her teeth. On 11/16/17, at 11:15 a.m. registered nurse (RN)-D was not aware if R102's missing tooth was recent. RN-D stated the 8/11/17, and the 10/17, oral assessments indicated R103 had no	F 278	A. MDS RN□s are aware of the expectation that the MDS should match the care plan, assessment, and Residents actual condition. B. All Staff educated on findings of F278 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. C. MDS Nurse reviewed MDS records from 11/1/17 to current to assure accuracy with all residents. Date of Completion: January 9, 2017 Recurrence will be prevented by: A. Facility will perform audits 2x□s per week for 3 months to assure MDS accuracy. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

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F 278	Continued From page 23 natural teeth. RN-D reviewed R103's care plan and verified the care plan indicated a lower denture and an upper partial. On 11/16/17, at 11:26 a.m. R103's teeth were observed with RN-D. RN-D verified R103 had a missing upper right tooth and the rest of R103's upper teeth appeared to be R103's natural teeth. R103 refused to allow or take out her lower partial. NA-G stated R103's bottom two front teeth were a partial and the rest of the teeth in 103's mouth were her own. On 11/16/17, at 11:57 a.m. RN-E stated an observation of the resident's mouth should be done when completing the MDS. RN-E stated all of R103's past MDS indicated R103 had her own teeth. On 11/16/17, at 1:34 p.m. the director of nursing (DON) stated she would expect the care plan, the MDS, and the oral assessment to match. The DON also stated the oral assessment should reflect what the resident actually had in their mouth.	F 278		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	F 309		1/9/18

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F 309	Continued From page 24 483.25 Quality of care Quality of care is a fundamental principle that 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper dining positioning for 1 of 3 residents (R18) reviewed for positioning. Findings include: R18's Diagnosis Report printed 11/15/17, indicated R18's diagnoses included spastic quadriplegic and hemiplegic cerebral palsy. R18's quarterly Minimum Data Set (MDS) dated	F 309	F309-D Corrective Action: A. R18□s care plan was reviewed and revised to indicate R18 will sit at the table as he chooses and staff are to assist resident to do so. R18 chooses to change his position when he likes based on his own choice. B. All Staff re-educated regarding following the Plan of Care and CNA group sheets.	

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F 309	Continued From page 25 8/21/17, indicated R18 required extensive assistance from staff with transfers. The MDS further indicated R18 ate independently after set up from staff. R18 did not have a swallowing disorder, weight loss or weight gain. On 11/13/17, R18 was observed in the Park Breeze dining room eating supper. R18 was seated reclined in his wheelchair, along side of the dining room table. R18's wheelchair was reclining to approximately 45 degrees, his feet were elevated with his knees bent above the table height. R18 was reaching right across his body with his left hand to reach his food. R18 picked up the chicken pot pie tin with his left hand, scooped the pot pie crust with his spoon, and dropped part of the crust on himself. R18 then picked up the pie crust with his fingers and ate it. R18 used his left hand to pick up the dish with cake, held it over his lap and ate it. On 11/15/17, at 9:14 a.m. R18 was interviewed and stated he preferred to sit up when eating. R18 stated when he was leaning back, it was uncomfortable and difficult to eat. R18 further stated he was placed in that position (reclined back) about once a week, usually in the afternoon at lunch or supper when staff did not sit him upright to eat. R18 stated he coughs and chokes at times when eating, and it is better when he was sitting up. On 11/15/17, at 12:01 p.m. registered nurse (RN)-C stated there were times R18 sat to the side of the table, and times R18 sats straight up at the table. RN-C further stated staff should be sitting him up and square to the table. On 11/15/17, at 2:34 p.m. the director of nursing	F 309	Corrective Actions as it applies to other Residents: A. All Staff educated on findings of F309 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. B. All residents were observed during meal time to assure proper positioning while dining. Date of Completion: January 9, 2017 Recurrence will be prevented by: A. Facility will perform compliance audits for positioning 4x□s per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

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F 309	Continued From page 26 (DON) stated she would expect staff to sit residents upright and at the table for meals. A resident meal positioning policy was requested and not received.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (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. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to prevent the development of a pressure ulcer for 1 of 3 residents (R104) reviewed for pressure ulcers. Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss	F 314	F314-D Corrective Action: A. RN□s and LPN□s re-educated to complete skin assessments weekly on bath day and to notify the Nurse Manager if the resident refuses. B. R104 was discharged from facility on 10/5/17. C. All Staff re-educated regarding following the Plan of Care and CNA group	1/9/18

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F 314	Continued From page 27 Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. R104's Diagnosis Report printed 11/16/17, identified diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease, diabetes, and chronic kidney disease. R104's admission Minimum Data Set (MDS) dated 8/28/17, indicated R104 was cognitively intact, and required extensive assistance with bed	F 314	sheets for repositioning and changing of briefs. D. □Prevention of Pressure Ulcers□ policy reviewed and dated. Corrective Actions as it applies to other Residents: A. All Staff educated on findings of F314 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. B. Facility assured all Residents with pressure ulcers have current weekly skin assessments. C. Facility reviewed all CNA group sheets to assure they match the plan of care for turning and repositioning residents. D. Facility reviewed all residents with current pressure ulcers and assured proper interventions are in place. E. Braden assessment shall be completed upon admission for all residents. F. Facility will perform repositioning tagging audits three times per week for three months to assure residents are repositioned according to the plan of care. Date of Completion: January 9, 2017 Recurrence will be prevented by: A. All Staff were educated on the □Prevention of Pressure Ulcers□ policy. B. Wound nurse hired and now performs weekly skin assessments with other nurse managers serving as back up in the absence of the wound nurse.	

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F 314	Continued From page 28 mobility, transfers and toileting. The MDS further indicated R104 was at risk of pressure ulcer development, but did not have any unhealed pressure ulcers. R104's significant change MDS, dated 10/2/17, indicated R104 required limited assistance for bed mobility and transfers, but continued to require extensive assistance with toileting. The MDS indicated R104 had one unstageable pressure ulcer with a suspected deep tissue injury in evolution. R104's care area assessment (CAA) for activities of daily living (ADL) functional and rehabilitation potential, dated 10/7/17, indicated a complication of immobility would be pressure ulcers. R104's pressure ulcer CAA indicated R104 was at risk of developing pressure ulcers, and had one unstageable pressure ulcer due to suspected deep tissue injury in evolution. R104's care plan dated 8/21/17, did not address R104's risk for the development of a pressure ulcer. A Braden Scale for for Predicting Pressure Score Risks was completed on 8/21/17, and R104 scored a 20, which indicated low risk for pressure ulcer development. A 9/11/17, progress note indicated R104 was admitted back to the facility from the hospital that afternoon. Review of progress notes from 9/12/17, to 9/26/17, indicated R104 had no pressure ulcers, and had been assessed at low risk for the development of pressure ulcers.	F 314	C. Facility will perform weekly audits for 3 months to assure weekly assessments are completed. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. D. Facility will perform compliance audits for proper interventions in place 2x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

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On 9/27/17, a progress note indicated R104 called registered nurse (RN)-G to her room. R104 stated her left foot was really sore. The progress note indicated R104 had an open area on her left heel that was 0.2 centimeters (cm) by 1.3 cm, and was draining serosanguinous (yellow, bloody fluid) drainage. The area was described as yellow in color with an area around the pressure ulcer that measured 5 cm by 3 cm and was closed and black in color. An order was received to apply betadine to the pressure ulcer, apply a foam border bandage to the area, and keep a heel protector on R104's left foot while she was in bed. This was identified as a new skin issue.

On 9/30/17, R104's Order Summary Report directed staff to clean the pressure ulcer on R104's left heel with betadine and apply a foam border dressing daily. Another 9/30/17, order directed staff to ensure each shift that R104 had the heel protector on her left foot while in bed to prevent rubbing. A third order dated 9/11/17, directed staff to complete a weekly skin assessment on bath day every Monday.

R104 was discharged from the facility on 10/5/17.

On 11/16/17, at 10:18 a.m. RN-D was interviewed and stated R104 spend most of her time in her wheelchair, and was alert and oriented. RN-D stated R104 slept in her chair for a while, and then went on hospice and began sleeping in bed. After being on hospice for a while, R104 changed her mind and went off of hospice. RN-D stated they put a blue heel boot on her when the pressure ulcer developed. RN-D agreed that the order did not specific which type of blue boot to use, and stated the facility had two types

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available in house: a Deroyal blue boot which was padded, but without a cut out for the heel (to reduce pressure), and one was a Prevalon boot, which went farther up the ankle, and had a cut out for the heel (for pressure relief. RN-D confirmed the order did not specify what boot to use, and the documentation did not specify what boot was used for R104. RN-D confirmed R104's pressure ulcer had not been thoroughly assessed by staging the pressure ulcer, and she would expect the pressure ulcer to be staged. RN-D also indicated the treatment Administration Record (TAR) was checked, indicating weekly skin assessments were completed, but confirmed the completed weekly assessments were not in R104's medical record. RN-D stated she would expect them to be. RN-D also stated R104 should have had interventions in place to prevent the pressure ulcer development. RN-G stated she was the first one to notice R104's pressure injury. RN-G stated R104 started complaining about her heel, so she took off R104's sock. RN-G stated the wound was draining with no depth, and there was a black outer ring, almost like a bruise. RN-G stated she didn't stage the wound as she has never been told she needed to stage pressure ulcers, believing that to be the job of the wound nurse. RN-G stated they changed the dressing daily and the black faded away, but R104 still complained of pain to that area. RN-G stated they could have paid closer attention to R104's skin, could have encouraged her to move more in bed and paid closer attention to her feet, as R104 was a diabetic.

The facility's undated Prevention of Pressure Ulcers policy directed staff to reposition bed fast residents at least every two hours and more frequently as needed. The policy further directed

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F 314	Continued From page 31 residents who are able to cooperate and understand should be taught to shift their weight every 15 minutes while sitting in a chair and change positions at least every 2 hours. The policy identified additional risk factors including co-morbid condition of end stage renal disease and diabetes.	F 314		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 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-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic	F 329		1/9/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 32 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that a resident had appropriate diagnosis, nonpharmalogical interventions were implemented and behavior was monitored when using an antipsychotic medication for 1 of 5 residents (R94) reviewed for unnecessary medications. Findings include: R94's Diagnosis Report printed 11/16/17, indicated R94's diagnoses included Alzheimer's, dementia with behavioral disturbances, restlessness and agitation, depression, mood disorder, anxiety and expressive language disorder. R84's admission Minimum Data Set (MDS) dated 8/29/17, indicated R94 was unable to complete the mental status interview. The MDS further indicated had no psychosis, but had physical and verbal behaviors directed toward others and other behaviors not directed toward others on 1-3 days during the assessment period. The MDS identified this behavior put R94 at significant risk for illness or injury and significantly interfered with R94's care and participation in activities and	F 329	F 329- D Corrective Action: A. Behavior charting shall be completed daily on R94. B. Non-pharmacological interventions and/or target behaviors will be documented prior to administering a PRN antipsychotic medication. Corrective Actions as it applies to other Residents: A. LPN□s, RN□s and TMA□s have been re-educated on □Antipsychotic Med Use□ policy and the expectation of non-pharmacological intervention documentation. B. Facility will assure all Residents on antipsychotics have target behaviors and non-pharmacological interventions. C. Antipsychotic medications will be reviewed during monthly during the meeting with Psychologist and Consultant Pharmacist. Date of Completion: January 9, 2017 Recurrence will be prevented by:	

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	245227	A. BUILDING _____ B. WING _____	C 11/17/2017

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F 329	Continued From page 33 social interactions. This behavior also put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment. R94 rejected care 1-3 days, and wandered daily putting R94 at risk of getting into a potentially dangerous place and intruding on the privacy of others. Additionally, the MDS identified R94 required supervision of one staff with bed mobility, ambulation, dressing and eating. The MDS identified R94 transferred independently and received antipsychotic medication on 5 of 7 days, and an antidepressant on 4 of 7 days during the assessment period. R94's care plan dated 8/29/17, indicated R94 used psychotropic medications related to dementia with behaviors, restlessness and agitation. The care plan directed to administer medications as ordered, monitor and document for side effects and effectiveness, and directed the facility to educate the resident, family and caregivers about the risks, benefits and the side effects of the medications. R94's Medication Administration Record (MAR) directed Risperdone 0.25 mg by mouth every four hours as needed for agitation related to restlessness and agitation. The medication was started on 8/28/17, and discontinued on 9/26/17. R94 received the as needed Risperdone one time on 9/4/17, and two times on 9/12/17. The MAR lacked nonpharmalogical interventions to implement prior to giving the medication, and adequate indications for use for the Risperdone. R94's MAR directed Trazadone 50 mg by mouth as needed for insomnia related to restlessness and agitation. The medication was started on	F 329	A. All Staff educated on findings of F329 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. B. Facility will perform antipsychotic med administration audits 2x□s per week for 2 weeks, then weekly audits for 4 weeks, then monthly x 3 months. Findings will be reported to the QAPI Committee for monthly review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person- Director of Nursing	

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8/22/17, and discontinued on 9/26/17. R94 received the as needed Trazadone twice on 9/2/17, and one time on 9/3/17, 9/11/17, 9/12/17, 9/13/17, 9/26/17, and 9/29/17. The MAR lacked nonpharmalogical interventions to implement prior to giving the medication.

R94's MAR directed Risperdone 0.25 mg by mouth every four hours as needed for agitation related to restlessness and agitation. The medication was started on 9/26/17, and discontinued on 10/9/17. R94 received the as needed Risperdone one time on 10/3/17, and 10/4/17. The MAR lacked nonpharmalogical interventions to implement prior to giving the medication, and adequate indications for use for the Risperdone.

R94's MAR directed Risperdone 0.25 mg by mouth every four hours as needed for agitation related to restlessness and agitation. The medication was started on 10/9/17, and discontinued on 11/9/17. R94 received the medication once on 10/20/17. The MAR lacked nonpharmalogical interventions to implement prior to giving the medication, and adequate indications for use for the Risperdone.

R94's MAR directed Trazadone 50 mg by mouth as needed for insomnia related to restlessness and agitation. The medication was started on 9/28/17, and discontinued on 11/9/17. R94 received the medication once on 10/2,10/ 3, 10/10/4, 10/10/8, 10/9, 10/101, 10/13, 10/16, 10/18, 10/20, 10/23, 10/26, 10/28, 10/29/17, and twice on 10/6/17. The MAR lacked nonpharmalogical interventions to implement prior to giving the medication.

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R94's MAR directed Risperdone 0.25 mg by mouth every four hours as needed for agitation related to restlessness and agitation. The medication was started on 10/9/17, and discontinued on 11/9/17. R94 received the medication once on 11/4, 11/5, 11/15, and 11/29/17. The MAR lacked nonpharmalogical interventions to implement prior to giving the medication, and adequate indications for use for the Risperdone.

R94's MAR directed Trazadone 50 mg by mouth as needed for insomnia related to restlessness and agitation. The medication was started on 9/28/17 and discontinued on 11/9/17. R94 received the medication once on 11/2, 11/4, 11/5, 11/6, 11/7, and 8/17. The MAR lacked nonpharmalogical interventions to implement prior to giving the medication.

Review of the nursing progress notes from 8/22/17, through 11/16/17, indicated the progress notes lacked nonpharmalogical interventions to implement prior to giving the as needed Risperdone and Trazadone, and adequate indications for use for the Risperdone.

On 11/14/17, at 2:52 p.m. R94 was observed off the unit at a music activity. At 2:54 p.m. R94 returned to the unit and ambulated independently. A nursing assistant (NA) approached R94, held out her hand and stated, "Come with me." R94 stood, took her hand and walked down the hall to his room.

On 11/15/17, at 12:25 p.m. R94 was observed at lunch. R94 was sitting at the table with three female residents and one staff. R94 was feeding himself. R94 was quiet, and alert. At 12:45 p.m.

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R94 finished eating and ambulated independently about the dining room.

On 11/17/17, at 9:04 a.m. R94 was observed sitting in an easy chair near the nursing desk with his hands in his lap. R94 was set up for coloring but was not coloring. R94 was talking nonsensical with his eyes closed and appeared sleepy.

On 11/16/17, at 4:09 p.m. the director of nursing (DON) was interviewed and stated R94 was admitted with the order for Risperdone. The DON verified the diagnosis for the Risperdone was dementia. The DON she was aware Risperdone was not recommended for dementia. The DON would expect instructions for nonpharmalogical interventions for as needed Risperdone and Trazadone to be included on the MAR and documented in the medical record.

On 11/17/17, at 9:06 a.m. NA-E was interviewed and stated she worked on the unit about twice a week. NA-E stated R94 was easily redirected, and she would take his hand, and walk with him to get him a cup of coffee. NA-E stated she has seen R94 standing over another male resident with his hand raised in a fist with both residents appearing to be in fight mode. NA-E stated she then would take R94's other hand and say, "Come with me," and he would go down the hall with her. NA-E stated R94 was worse in the afternoon. NA-E further stated R94 would swing his arms when he talked, and was very animated.

On 11/17/17, at 9:19 a.m. licensed practical nurse (LPN)-B was interviewed and stated R94's days were good, but he had more behaviors in the afternoon. LPN-B further stated R94's behaviors had been good recently, but in the past

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F 329	Continued From page 37 if someone got in his way he would go into fight mode. LPN-B stated prior to giving an as needed medication she would try to calm R94 by offering a snack, and providing a calm environment. LPN-B verified there were no nonpharmalogical interventions listed in R94's medical record. A policy on indications for use for antipsychotic medications was requested and not provided.	F 329		
F 356 SS=C	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data	F 356		1/15/18

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F 356	Continued From page 38 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the current nurse staff posting was posted and updated with changes. This had the potential to affect all 111 residents residing in the facility. Findings include: On 11/13/17, at 11:56 a.m. the facility nurse staff posting located next to the reception desk, was dated 10/24/17. On 11/13/17, at 1:38 p.m. the nurse staff posting had been changed and was dated 11/13/17. The posting that was previously posted was requested from the administrator, and the posting provided was dated 10/24/17. The administrator stated the	F 356	F 356-C Corrective Action: A. 'Posting Direct Care Daily Staffing Numbers' policy has been reviewed and dated. B. Staffing Coordinator and Director of Human Resources reviewed F356 regulations. Corrective Action as it applies to other Residents: A. The LPN's and RN's have been educated on the daily and shift requirements of posted nurse staffing information. B. Human Resources will post or provide the staffing posting to shift Charge Nurse	

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F 356	Continued From page 39 staffing coordinator in human resources (HR), was to post it daily. On 11/14/17 at 8:50 a.m. the nurse staff posting was dated 11/13/17, with no changes noted on the posting. On 11/14/17, at 11:50 a.m. the nurses staff posting was dated 11/14/17. The nurse staff postings and direct care staff schedules between 10/24/17, and 11/13/17 were reviewed and revealed the nurse staff postings did not reflect the staffing changes. On 11/16/17, at 10/23/17, the staffing coordinator (SC) verified the posting on 11/13/17, was dated 10/24/17, and had not been posted since that date. SC stated the nurse staff postings had been done, but had not been posted, and should have been posted daily after morning briefing. SC also verified the nurse staff postings did not reflect the changes in staffing each shift. The undated facility policy and procedure for Posting Direct Care Daily Staffing Numbers, directed the number of licensed nurses and unlicensed nursing staff directly responsible for resident care, would be posted within 2 hours of the beginning of each shift.	F 356	to post. C. Shift updates shall be completed timely by Human Resources and shift Charge Nurse Date of Completion: January 15, 2017 Recurrence will be prevented by: A. All Staff educated on findings of F356 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. B. Facility will perform posting compliance audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly x 3 months. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Human Resources	
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428		1/9/18

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pharmacist.

(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.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(5) The facility must develop and maintain policies

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F 428	Continued From page 41 and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the consultant pharmacy recommendations were addressed in a timely manner for 1 of 5 residents (R129) reviewed for unnecessary medications. Findings include: R129's Diagnosis Report, printed 11/16/17, indicated diagnoses that included dementia without behavioral disturbances, age-related cognitive decline and restlessness and agitation. R129's quarterly Minimum Data Set (MDS) dated 10/10/17, indicated R129 had severely impaired cognition, had mild depression, rejected care 4 to 6 days in the assessment period and wandered daily. The MDS further indicated R129 had dementia and was independent or needed only supervision for all activities of daily living (ADL's). Additionally, the MDS indicated R129 had had one fall with injury. R129's care plan dated 5/23/17, indicated he used an antidepressant medication for agitation. Interventions included to monitor/document side effects and effectiveness of the medication and to monitor/document and report to the physician ongoing signs and symptoms of depression unaltered by antidepressant medications. R129's care plan also identified the use of a psychotropic	F 428	F 428- D Corrective Action: A. R129□s PRN quetiapine was discontinued 11/17/17 as recommended by the Consultant Pharmacist. Corrective Actions as it applies to other Residents: A. Facility Consultant Pharmacist will make monthly medication reviews. B. Pharmacist recommendations will be forwarded by facility staff to residents physicians for appropriate action and resolved within 30 days or a note will be made if a longer resolution is necessary. C. Facility will review Consultant Pharmacist recommendations from November 2017 to assure all recommendations are addressed. Date of Completion: January 9, 2017 Recurrence will be prevented by: A. All Staff educated on findings of F428 and corrective action the Facility has made. Education was provided in three large group meetings, several small group meetings and 1:1 education. B. Facility will perform audits 2x□s per week for 2 weeks, then weekly audits for 4 weeks, then monthly x 3 months to	

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F 428	Continued From page 42 medication for agitation. Interventions included to administer medications as ordered, monitor and document for side effects and effectiveness of the medication and consult with pharmacy and the physician to consider dosage reduction when clinically appropriate. The care plan further identified R129 had the potential to demonstrate verbally abusive and physical behaviors related to his dementia diagnosis and was resistive to cares. The care plan interventions included: - analyze key times, places, circumstances, triggers and what was effective to de-escalate his behaviors - assess and anticipate needs -assess understanding of the situation and allow time to express self and feelings -evaluate for side effects of mediations -intervene before agitation escalates, guide away from source of distress, engage calmly in conversation -encourage as much participation/interaction by the resident as possible during care activities -give clean explanation of all care activities prior to and as they occur during each contact -if resident resists with ADLs, reassure resident, leave and return 5-10 minutes later -call the resident by name when providing care and involved him in -involve resident in activities of interest and social functions -provide reorientation to environment and reminders daily and prn -routinely monitor resident where-a-bouts and escort away from exit doors A consultant pharmacist note dated 7/27/17, indicated R129 was admitted on 5/10/17, with orders that included 20 mg of fluoxetine (an antidepressant) daily and 12.5 mg quetiapine (an	F 428	assure recommendations are followed through. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person- Director of Nursing	

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antipsychotic medication) once daily as needed (PRN) for agitation/delirium. The note recommended the PRN quetiapine be discontinued at that time.

A physician progress note dated 9/5/17, indicated R129 was a flight risk and had impulsitivity and decreased insight. The note further indicated the donepazil was not helping and the facility should "consider stopping" the medication.

A consultant pharmacist note dated 10/24/17, indicated R129's quetiapine prescription was still intact. The consultant pharmacist again recommended discontinuation as there had been no use in the last 30 days. The note further indicated that the quetiapine had been used three times since the original recommendation for non-specific episodes of "agitated" behavior.

On 11/14/18, R129 was calm and polite, but confused, during an interview and observation.

On 11/15/17, at 11:55 a.m. R129 was observed independently walked into the memory care dining room, patted one resident on the cheek, patted a second resident on the shoulder, and sat down next to them. R129, humming, placed a cover up around his neck and sat at the table with the other two residents until 12:03 p.m. when his food arrived, at which point he sat and ate with no incident.

R129's medication administration record (MAR) indicated he received donepezil HCl (a medication for memory) 10 mg by mouth daily at bedtime for dementia; fluoxetine HCl (an antidepressant), 20 mg daily for agitation in November. R129 also received quetiapine

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F 428	Continued From page 44 fumarate (an antipsychotic medication) 12.5 mg twice in November for agitation. On 11/16/17, at 3:19 p.m., the director of nursing (DON) stated consultant pharmacist recommendation should be addressed, either rejected or accepted, within the month. A copy of R129's behavior monitoring was requested but not received from the facility. A copy of physician notes addressing the consultant pharmacist recommendations was requested but not received from the facility. The facility was unable to provide a policy on consultant pharmacist's recommendations.	F 428		
F 441 SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (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: (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 §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures	F 441		1/15/18

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	245227	A. BUILDING _____ B. WING _____	C 11/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 45 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. (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 46 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 ensure infection control practices were maintained during eating when a staff blew on food for 1 of 2 residents (R2) who required assistance with eating. In addition, the facility failed to ensure proper hand hygiene was maintained during wound care, and a catheter bag was kept off of the floor for 1 of 1 residents (R48) observed for wound care. In addition, the facility failed to ensure proper infection control precautions and proper room cleaning was completed for 1 of 1 residents (R96) reviewed for isolation precautions. In addition, the facility failed to ensure a Legionella policy was developed for identification and prevention of Legionella. This had the potential to affect all 111 residents residing in the facility. In addition, the facility failed to develop an infection control program that included comprehensive tracking and trending of infections. This had the potential to affect all 111 residents residing in the facility. Findings include: R2's Admission Record printed 11/16/17, indicated R2's diagnoses included dementia, Alzheimer's disease, and quadriplegia. R2's quarterly Minimum Data Set (MDS) dated 8/21/17, indicated R2 had moderately impaired	F 441	F 441- F Corrective Action: A. R48 has a catheter bag cover. B. Employee NA-D was educated not to blow on Residents food. Employee NA-D no longer works at the Facility. C. 'Infection Control Guidelines for All Nursing Procedures' policy has been reviewed and dated. D. Isolation precaution signage was updated with recommendations from ICAR. Signage now states the type of precautions and instructions for donning and doffing personal protective equipment E. 'Assistance with Meals' policy has been reviewed and dated. F. 'Emptying a Urinary Drainage Bag' policy has been reviewed and dated. G. The Facility form for tracking infections has been updated to include a space to indicate the organism causing the infection. H. The 'Legionnaires Disease' policy has been updated and dated. Corrective Action as it applies to other Residents: A. The 'Infection Control Surveillance' policy has been reviewed and dated. B. Facility staff assured all residents with	

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F 441	Continued From page 47 cognition and required extensive assistance from staff with eating. On 11/13/17, at approximately 6:00 p.m. during the supper meal in the Park Breeze dining room nursing assistant (NA)-D was observed blowing on R2's hot food prior to putting the food into R2's mouth. NA-D blew on each spoonful of hot food throughout the supper meal. Licensed practical nurse (LPN)-A was also sitting at the table assisting another resident with eating. On 11/13/17, at 6:06 p.m. NA-D stated she usually blows on the resident's food when it is too hot. NA-D further stated it was instinctual. On 11/15/17, at 2:39 p.m. the director of nursing (DON) stated staff should not be blowing on the resident's food to cool it. The facility's Assistance with Meals policy undated, directed all employees who provided resident assistance with meals would be trained and would demonstrate competency in the prevention of foodborne illness. This included safe food handling. R48's Admission Record, printed 11/16/17, indicated R48's diagnoses included pressure ulcers, recent history of sepsis (a potentially life-threatening complication of an infection) and urinary tract infection, and dementia. R48's care plan revised 11/15/17, indicated R48 had an indwelling catheter (tube that drains urine from the bladder into a bag outside the body) related to skin breakdown, was at risk for urinary tract infections, and had current pressure ulcers. The care plan further indicated R48 required staff	F 441	a catheter had a cover on the catheter bag. C. The 'Cleaning and Disinfection of Environmental Surfaces' policy has been reviewed and dated. D. Bleach mixing directions were posted in each housekeeping mixing closet. E. Common Chemical Education picture guides posted at nurses stations and in housekeeping mixing closets to educate staff on proper chemicals to use for disinfecting and for C-Diff. Date of Completion: January 15, 2017 Recurrence will be prevented by: A. All Staff received education on proper handwashing and gloving, Legionnaires Disease, proper infection control practices while assisting with meals, isolation precautions for C-Diff, urinary bag cover expectations, tracking and trending of infections, and cleaning and disinfecting of environmental surfaces. B. Facility will perform 'Bayshore Handwashing and Gloving' audits 4x's per week for 3 weeks, then weekly audits for 4 months. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. C. Facility will perform catheter bag placement and cover audits 4x's per week for two weeks, then weekly for 4 months. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits	

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F 441	Continued From page 48 assistance with mobility, personal cares, catheter cares, and pressure ulcer wound care. The care plan lacked direction for placement of the catheter bag to prevent infection. R48's discharge summary from her hospitalization from 10/14/17, through 10/19/17, indicated R48 was hospitalized with urosepsis (a potentially life threatening urinary infection that has entered the bloodstream). R48's discharge summary further indicated R48 had a catheter due to skin wounds, and indicated that it would be best if the catheter was removed as soon as was possible. On 11/16/17, at 8:22 a.m. R48's catheter bag was observed to be laying on the floor. At that time, registered nurse (RN)-B stated it was hard to hang the catheter bag on R48's bed, and the bed was in the low position. RN-B verified the catheter bag should not be on the floor and said there was no good place to hang it. On 11/16/17, at 8:37 a.m. RN-A and RN-B were observed changing R48's pressure ulcer dressings. RN-B cleansed R48's sacrum pressure ulcer with wound cleanser and removed gloves. RN-B directly donned clean gloves without sanitizing or washing between glove changes. RN-B opened a new dressing, completed wound care as ordered, and placed a new dressing on R48's pressure ulcer. RN-B then removed the dressing from R48's right upper hip which contained a moderate amount of serosanguinous (thin and watery, and blood-tinged) drainage. RN-B disposed of the dressing, removed gloves and began to put on clean gloves. RN-A cued RN-B to sanitize hands between glove changes. RN-B continued to don	F 441	may be discontinued. D. Facility will weekly audit for 3 months that all chemical postings are maintained and housekeeping staff are mixing the chemicals correctly. E. Facility will perform dining audits twice per day 4x's per week for 2 weeks, then audits 4x's per week for 4 weeks, then weekly audits for 3 months. Findings will be reported to the QAPI Committee monthly for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. F. Facility hosted ICAR for visit and to receive recommendations. Responsible Person: Administrator	

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clean gloves without sanitizing. RN-B measured the right hip pressure ulcer, cleansed the pressure ulcer edges with wound cleanser, completed the wound care, packed the wound and dressed the wound as ordered. RN-B then removed her gloves and sanitized her hands, before donning clean gloves and completing wound care. The catheter bag continued to hang on the floor.

On 11/16/17, at 9:13 a.m. R48's catheter bag remained hanging on the floor. RN-A was interviewed and stated the catheter bag usually hung on the floor, and verified the catheter bag should not be on the floor. RN-A verified R48 has had urinary tract infections and urosepsis. RN-B also verified she did not sanitize her hands between glove changes, and stated she should have.

On 11/16/17, at 10:56 a.m. the director of nursing (DON) was interviewed and verified catheter bags should not be on the floor due to risk of infection. The DON stated R48 had recently received a low bed, so the catheter bag touched the floor when hung on the bed.

The undated facility policy and procedure for Infection Control Guidelines for All Nursing Procedures, directed hands must be washed with soap and water or sanitized after removing gloves, contact with body fluids, or moving from a contaminated body site to a clean body site.

The undated facility policy and procedure for Emptying a Urinary Drainage Bag, directed to keep the drainage bag and tubing off the floor at all times to prevent contamination.

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R96's Admission Record printed 11/16/17, indicated R96's diagnoses included multiple sclerosis.

R96's physician orders dated 11/16/17, indicated R96 received Flagyl (antibiotic) for a clostridium difficile (bacterial infection in the bowel, that causes watery, diarrhea, also known as C. diff).

R96's care plan revised 6/17, directed staff to provide extensive assistance of 2 staff for toilet use, and to transfer to and from the toilet using a hoyer lift with a toilet sling. R96's care plan further indicated R96 was incontinent of bowel.

A review of R96's progress notes indicated R96 first reported loose stools on 11/2/17, after treatment with antibiotics for an abscess. R96 continued with loose stools and a C. diff infection was identified on 11/9/17, through culture results. R96 was placed on precautions and began treatment with Flagyl on 11/9/17. R96's progress notes dated 11/14/17, indicated R96 continued to have loose stools, or symptoms of C. diff.

On 11/13/17, during the initial tour at 11:51 a.m. R96 had an isolation cart outside the room with gloves, gowns and bleach wipes on it. A sign on R96's room door directed a gown, gloves and handwashing were needed in that room. At that time, nursing assistant (NA)-A was observed in R96's room wearing gloves but no gown, standing at R96's bedside. NA-A removed her gloves, sanitized her hands, and left the room carrying a container of yogurt and a container of juice that she had taken from R96's tray table. NA-A carried the containers to the nurse's station and threw them in the garbage can, then went into the room behind the nurse's station with a refrigerator and

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sink, and washed her hands in the sink, which contained 2 dirty food bowls and an empty butter bin. NA-A was interviewed and stated she had been told they did not have to wear a gown in R96's room unless they were providing cares. NA-A stated the dishes in the sink would be put on a dish rack and taken to the kitchen to be washed.

On 11/15/17, at 7:33 a.m. housekeeper (H)-A was observed cleaning in R96's room. H-A was wearing gloves and a gown, and was mopping R96's room and bathroom. H-A used bleach wipes to wipe off the tables in R96's room, and to clean the mop handle. H-A stated she used bleach to clean the toilet and tables in R96's room, and used OdoBan for mopping the floors. H-A showed surveyor the container of OdoBan, and the label lacked indication that OdoBan was appropriate for cleaning and disinfecting for C. diff.

On 11/15/17, at 11:43 a.m. environmental services director (ESD) was interviewed and verified OdoBan was not appropriate for use with C. diff, and stated it should be a 1:8 bleach solution. The ESD stated bleach wipes should be used on touch surfaces. The ESD had directed housekeeping to re-clean R96's room with bleach.

On 11/15/17, at 11:46 a.m. registered nurse (RN)-H stated R96 was incontinent of bowel at this time, but stated it was contained in an incontinent brief, and R96 did not participate in toilet use or changing of incontinent brief.

On 11/16/17, at 10:52 a.m. RN-A verified staff should gown every time they are in R96's room,

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even if not providing direct care, because there was a potential for contamination. At that time, the director of nursing (DON) verified OdoBan was not sufficient for cleaning rooms with C. diff. and stated staff should be using a bleach solution.

On 11/16/17, at 11:09 a.m. RN-A verified there had been no evidence of the spread of C. diff infection to other residents.

The facility policy and procedure for Clostridium Difficile undated, directed disinfection of items with potential fecal soiling would be completed with a disinfecting agent recommended for C. diff, such as bleach and water solution or an Environmental Protection Agency (EPA) registered germicidal agent effective against C. diff spores. The policy further directed all residents with diarrhea associated with C. diff would be placed on contact precautions, to include healthcare workers would wear gloves and gowns upon entering the room of a resident with C. diff and would remove gowns and gloves prior to exiting the room.

The facility policy and procedure for Cleaning and Disinfection of Environmental Surfaces undated, directed the use of 1:10 dilution of household bleach would be used for routine environmental cleaning in units with C. diff, and noted that no products are EPA-registered specifically for inactivating C. diff spores.

The facility policy and procedure for Legionnaire's disease was reviewed. The facility policy lacked direction for identification of facility risk, prevention, water management protocols, and surveillance for Legionella (a severe form of

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F 441	Continued From page 53 pneumonia, caused by bacteria that can live in potable and non-potable water). On 11/16/17, at 11:08, the DON verified the policy did not address Legionella risk and prevention. A review of the facility Resident Monthly Infection Tracking Logs for September through November 2017, indicated the logs and the Individual Infection Report/Resident forms lacked identification of the organism causing the infection or the colony count (number of colony forming units of bacteria per milliliter). On 11/16/17, at 11:09 a.m. RN-A verified tracking and trending of infections was not comprehensive with the current system, and did not include the organism and colony count for the infections. A policy and procedure for the infection control program was requested but not provided.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Bayshore Health 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/17/2017

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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Or by email to:
Marian.Whitney@state.mn.us
or
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Bayshore Health Center is a 2-story building with a no basement. The original building was constructed in 1969 with an addition in 1978. The original building buildings and additions are all Type II (111) construction, therefore, the facility was inspected as one building.

The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification.

The facility has a licensed capacity of 139 beds and had a census of 110 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING	K 222		1/15/18

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

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K 222	Continued From page 3 ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.2.2.2 and, 7.2.1.1.2, 7.2.1.6 and the 2015 MN State Fire Code, Appendix I. This deficient practice could affect 16 of 110 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m.	K 222	K222-D Corrective Action: 1. All the exits in memory care will have the code posted near the keypad informing visitors and staff how to disengage the door locks to exit. 2. Exit doors in this unit will be painted a color that is different than the walls so that they are recognizable as an exit.	

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K 222	Continued From page 4 on 11/16/2017, Observation revealed the following deficient conditions affecting the exit door: 1. The memory care unit has a coded keypad used to unlock the door to the exit, but did not have a the code or instructions on how to open the door posted at the location of the keypad. 2. The exit door in the memory care unit was painted the same color walls and is blending into the adjoining walls making the exit door unrecognizable. This deficient condition was verified by a Maintenance Supervisor.	K 222	Date of completion: January 15, 2018. Person responsible: Maintenance Director.	
K 291 SS=F	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 observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested and maintained in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect 110 of 110 residents, as well as an undetermined number of staff, and visitors in the event of an emergency evacuation during a power outage. Findings include:	K 291	K291-F Corrective Action: 1. Documentation of 30 second monthly and 90 minute annual test of battery operated lighting will be done. Documentation will be filed for annual review. Date of completion: January 15, 2018. Person responsible: Maintenance Director	1/15/18

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K 291	Continued From page 5 On facility tour between 10:00 a.m. to 3:00 p.m. on 11/16/2017, observation during a review of all available testing and maintenance documentation and an interview with the Maintenance Supervisor revealed that the facility had not conducted the 90 minute annual test of the battery operated emergency lights found within the facility. This deficient condition was verified by a Maintenance Supervisor.	K 291		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not maintained the fire alarm system testing and maintenance in accordance with NFPA 72 National Fire Alarm Code 2010 edition. This deficient practice could affect 110 of 110 residents,as well as an undetermined number of staff, and visitors to the facility.	K 345	K345-F Corrective Action: 1.Completed an annual fire alarm test on November 29, 2017 and filed the report to verify compliance. Date of completion: November 29, 2017.	11/29/17

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K 345	Continued From page 6 Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/16/2017, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required annual testing of the facility's fire alarm system. This deficient condition was verified by a Maintenance Supervisor.	K 345	Person responsible: Maintenance Director	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or	K 363		11/29/17

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K 363	Continued From page 7 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition section 19.3.6.3.13. This deficient practice could affect 14 of 110 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/16/2017, observations revealed that there were two Dutch style doors located in the memory care unit that had door leaves that did not latch into each other. This deficient condition was verified by a Maintenance Supervisor.	K 363	K363-D Corrective Action: 1. Remove manual locks and install self latching hardware so the door leaves automatically latch when closed. Date of completion: November 29, 2018. Person responsible: Maintenance Director	
K 712	Fire Drills	K 712		1/15/18

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K 712 SS=F	Continued From page 8 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 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 110 of 110 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/16/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed the facility did not have the signatures of staff members that participated during the fire drill on 3 of 12 fire drill documents.	K 712	K712-F Corrective Action: 1.Facility will provide and file documentation of member participation for all fire drills held throughout the calendar year. Person Responsible: Maintenance Director	

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K 712	Continued From page 9 This deficient condition was verified by a Maintenance Supervisor.	K 712		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, the facility's written smoking policy is not in accordance with National Fire Protection	K 741	K741-F Corrective Action: 1. The area the resident came from has	1/15/18

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K 741	Continued From page 10 Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition, Section 19.7.4. This deficient practice could affect 110 of 110 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/16/2017, observations revealed that the at the time of the inspection upon entering the exit access a resident was seen holding a cigarette that was lit and still emitting smoking in the corridor as he was returning to his room. This deficient condition was verified by a Maintenance Supervisor.	K 741	been thoroughly cleaned and an alarm has been placed on the door to prevent this area from being an area to smoke. Smoking will only be done in the approved smoking areas and are to be maintained in a cleanly manner. Date of completion: January 15, 2018. Person responsible: Maintenance Director	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice	K 901	K901-F Corrective Action: 1. Complete the categorical risk assessment documentation of the facility	1/15/18

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K 901	Continued From page 11 could affect 110 of 110 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/16/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed categorical risk assessment document at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901	and file for annual review. Date of completion: January 15, 2018. Person responsible: Maintenance Director	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated	K 914		1/15/18

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K 914	Continued From page 12 repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 110 of 110 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/16/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914	K914-F Corrective Action: 1. Complete and document an annual electrical outlet inspection and testing of receptacles in patient rooms. Documentation will be stored for annual review. Date of completion: January 15, 2018 Person responsible: Maintenance Director	