DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: Y9ZW Facility ID: 00589

MEDICARE/MEDICAID PROVID (L1) 245227 2.STATE VENDOR OR MEDICAID II (L2) 1821433426 5. EFFECTIVE DATE CHANGE OF (L9) 07/01/2013	NO.	3. NAME AND ADDRESS OF FACILITY (L3) BAYSHORE RESIDENCE & REHAB (L4) 1601 ST LOUIS AVENUE (L5) DULUTH, MN 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			(L6) 55802 02 (L7) 13 PTIP 22 CLIA	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey A	2. Recertification 4. CHOW 6. Complaint 9. Other	
6. DATE OF SURVEY 01/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	0/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	DING DATE: (L35)	
11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	139 (L18) 139 (L17)	Compliance1. A B. Not in Con		ram	And/Or Approved Waivers Or 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural States) 5. Life Safety Code * Code: A*	el 6. Scope of 7. Medical	Services Limit Director oom Size	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 139 (L37) (L38)	0WN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REM See Attached Remarks	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:	
Kimberly Settergren, HF	E NEII	0	02/072017	(L19)	Mark Weath, Enforcement Specialist 04/06/2017 (L20)			
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	AL OFFICE OR SINGLE STATE AGENCY			
19. DETERMINATION OF ELIGIBII _X 1. Facility is Eligible to 1 2. Facility is not Eligible	Participate		IPLIANCE WITH HTS ACT:	I CIVIL	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	23. LTC AGREED BEGINNING		4. LTC AGREEM ENDING DAT		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure	<u>0</u> <u>INVOL</u>	(L30) <u>UNTARY</u> to Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI	VE SANCTIONS	(L25)		02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminati	sement 06-Fail	to Meet Agreement	
(L27)		n of Admissions: uspension Date:	(L44) (L45)		04-Other Reason for Withdrawal	07-Prov 00-Acti	vider Status Change ve	
(L27) 28. TERMINATION DATE:	B. Rescind S		(L45)	(L31)	04-Other Reason for Withdrawal 30. REMARKS	07-110	-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00589

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5227

On January 20, 2017 a Post Certification Revisit (PCR) was completed to verify the facility had achieved and maintained compliance pursuant to a PCR completed December 21, 2016. Based on our PCR we have determined deficiencies not corrected at the PCR completed on December 21, 2016 pursuant to the October 27, 2016 were corrected, effective January 16, 2017.

As a result of our finding the facility achieved compliance, we have discontinued the Category 1 remedy of State monitoring, as of December 16, 2016.

In addition, we are recommending the following action to the CMS Region V Office, related to the enforcement remedies in our letters of January 4, 2017 and February 7,

- Mandatory Denial of payment for new Medicare and Medicaid admissions (DPNA), effective January 27, 2017, be rescinded. (42 CFR 488.417 (b))

Since DPNA did not go into effect the facility would not be subject to a two year loss of NATCEP which was to begin January 27, 2017.

Refer to our February 7, 2017 eNotice for the details of this revisit.

Effective January 16, 2017, the facility is certified for 139 skilled nursing facility beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245227

April 6, 2017

Mr. David Uselman, Administrator Bayshore Residence & Rehabilitation Center 1601 St Louis Avenue Duluth, Minnesota 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 January 16, 2017 the above facility is certified for:

139 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 7, 2017

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

RE: Project Number S5227027

Dear Mr. Uselman:

On January 4, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective January 9, 2017. (42 CFR 488.422)

In addition, on January 4, 2017, as authorized by Centers for Medicare and Medicaid Services (CMS), we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 27, 2017. (42 CFR 488.417 (b))

Furthermore, in our letter of January 4, 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 [NATCEP January 27, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on October 27, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on December 21, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On January 20, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 8, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 21, 2016, as of January 16, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective January 16, 2017.

Bayshore Residence & Rehabilitation Center February 7, 2017 Page 2

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of January 4, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 27, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 27, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 27, 2017, is to be rescinded.

In our letter of January 4, 2017, we advised you 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 27, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 16, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

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

Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVI	ISIT			
	A. Building B. Wing		Y2	1/20/2017	Y3			
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE						
BAYSHORE RESIDENCE & RE	EHAB CTR	1601 ST LOUIS AVENUE						
		DULUTH, MN 55802						

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

ITE Y4		DATE Y5	ITEM Y4	DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0431	Correction	ID Prefix F0441	Correction	ID Prefix		Correction
Reg. #	483.60(b), (d), ((e) Completed	Reg. # 483.65	Completed	Reg. #		Completed
LSC		01/16/2017	LSC	01/16/2017	LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC _		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS) TA/mm	DATE 02/07/2017	SIGNATURE OF SURVEYOR 34	089	DATE 01/20	/2017
REVIEWS CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/27/2016			R ANY UNCORRECTED DEFICIE TED DEFICIENCIES (CMS-2567		E EA OU ITVO	s 🗆 NO	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronically Delivered February 7, 2017

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

RE: Project Number S5227027

Dear Mr. Uselman:

On January 20, 2017, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on January 20, 2017, imposed a daily fine in the amount of \$600.00.

On January 20, 2017, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on January 20, 2017 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$600.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$104.40, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$704.40 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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

	STATE FORM: REVISIT REPORT									
IDENTIFI	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CON A. Building	ISTRUCTIC	N				DATE OF RE'		
NAME O	00589 NAME OF FACILITY BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802							Y3		
correctiv	This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).									
ITE	М	DATE	ITEM	1	DATE	ITEM		DAT	ΓΕ	
Y4		Y5	Y4		Y5	Y4		Y	5	
ID Prefix	21375	Correction	ID Prefix	21610	Correction	ID Prefix		Corr	ection	
Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN Rule 4658.134 Subp. 1	Completed	Reg. #		Com	pleted	
LSC	•	01/16/2017	LSC		01/16/2017	LSC				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: Y9ZW Facility ID: 00589

1. MEDICARE/MEDICAID PROVID (L1) 245227 2. STATE VENDOR OR MEDICAID II (L2) 1821433426 5. EFFECTIVE DATE CHANGE OF (L9) 07/01/2013 6. DATE OF SURVEY 12/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATIO From (a): To (b):	OWNERSHIP 1/2016/ (L34) (L10)	3. NAME AND AI (L3) BAYSHORE (L4) 1601 ST LO (L5) DULUTH, M 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 10.THE FACILITY A. In Compliance	E RESIDENCI UIS AVENUE AIN JPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICE/IID 12 RHC	(L6) 55802 <u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF		2. Recertification 4. CHOW 6. Complaint 9. Other r Complaint NG DATE: (L35)
12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDO	139 (L18) 139 (L17)	Compliance 1. X B. Not in C	e Based On: Acceptable POC Compliance with and/or Applied W	Program	3. 24 Hour RN 4. 7-Day RN (Rural S) 5. Life Safety Code * Code: B *	7. Medical Di	rector m Size
18 SNF 18/19 SNF 139 (L37) (L38) 5. STATE SURVEY AGENCY REMARK See Attached Remarks	19 SNF (L39)	ICF (L42) E SHOW LIC CANC	IID (L43) ELLATION DAI	IE):	1861 (e) (1) or 1861 (j) (1):	(L15)	
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Suan Frericks, HPR SWS 01/17/2017 (L19)							
Suan Frericks, HPR SWS	S		01/17/2017	(L19)	Mark Meath	, Enforcement Spec	cialist 02/01/2017 (L20
				` /	Mark Meath		02/01/2017
	RT II - TO BE (LITY Participate	COMPLETED I		EGIONAL	OFFICE OR SINGLE S 21. 1. Statement of Fina	STATE AGENCY ancial Solvency (HCFA-257 rol Interest Disclosure Stmt	(L20)
PA 19. DETERMINATION OF ELIGIBIN _X 1. Facility is Eligible to	RT II - TO BE (LITY Participate e (L21)	COMPLETED I 20. COM RIGH	BY HCFA RI	EGIONAI H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr	STATE AGENCY ancial Solvency (HCFA-257 rol Interest Disclosure Stmt e:	(L20 (72) (HCFA-1513)
PA 19. DETERMINATION OF ELIGIBII _X 1. Facility is Eligible to 1 2. Facility is not Eligible	RT II - TO BE (LITY Participate	20. COMPLETED I 20. COM RIGH	BY HCFA RI IPLIANCE WITI HTS ACT:	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure	STATE AGENCY ancial Solvency (HCFA-257 tol Interest Disclosure Stmt te :	(L20 72) (HCFA-1513)
PA 19. DETERMINATION OF ELIGIBIT X 1. Facility is Eligible to 1 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION	RT II - TO BE (LITY Participate (L21) 23. LTC AGREEN	20. COMPLETED I 20. COM RIGH	BY HCFA RI IPLIANCE WITH HTS ACT: 4. LTC AGREEN	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	STATE AGENCY ancial Solvency (HCFA-257 tol Interest Disclosure Stmt e: 1: 1: 1: 1: 1: 1: 1: 1: 1:	(L20 72) (HCFA-1513) (L30)
PA 19. DETERMINATION OF ELIGIBID _X 1. Facility is Eligible to 1 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 01/22/1979	Participate e (L21) 23. LTC AGREEN BEGINNING (L41) 27. ALTERNATI A. Suspension	20. COMPLETED I 20. COMPLETED	BY HCFA RI IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DA	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure	STATE AGENCY ancial Solvency (HCFA-257 rol Interest Disclosure Stmt e: I: 0	(L20 72) (HCFA-1513) (L30) NTARY Meet Health/Safety Meet Agreement er Status Change
PA 19. DETERMINATION OF ELIGIBII X 1. Facility is Eligible to 1 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 01/22/1979 (L24) 25. LTC EXTENSION DATE:	Participate e (L21) 23. LTC AGREEN BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COMPLETED I 20. CO	BY HCFA RI IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DA (L25) (L44) (L45)	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	STATE AGENCY Incial Solvency (HCFA-257 rol Interest Disclosure Stmt e: I: O INVOLUM 05-Fail to sement 06-Fail to on OTHER 07-Provid	(L20 72) (HCFA-1513) (L30) NTARY Meet Health/Safety Meet Agreement er Status Change
PA 19. DETERMINATION OF ELIGIBIT X 1. Facility is Eligible to 1 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 01/22/1979 (L24) 25. LTC EXTENSION DATE: (L27)	Participate e (L21) 23. LTC AGREEN BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COMPLETED I 20. CO	BY HCFA RI IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DA (L25) (L44) (L45)	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	STATE AGENCY Incial Solvency (HCFA-257 rol Interest Disclosure Stmt e: I: O INVOLUM 05-Fail to sement 06-Fail to on OTHER 07-Provid	(L20 72) (HCFA-1513) (L30) NTARY Meet Health/Safety Meet Agreement er Status Change
PA 19. DETERMINATION OF ELIGIBIT X 1. Facility is Eligible to 1 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 01/22/1979 (L24) 25. LTC EXTENSION DATE: (L27)	RT II - TO BE (LITY Participate e (L21) 23. LTC AGREET BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COMPLETED I 20. CO	BY HCFA RI IPLIANCE WITH HTS ACT: 4. LTC AGREEN ENDING DA (L25) (L44) (L45) //CARRIER NO.	EGIONAL H CIVIL MENT TE	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	f: O INVOLUM 05-Fail to sement 06-Fail to 00 OTHER 07-Provid 00-Active	(L20 72) (HCFA-1513) (L30) NTARY Meet Health/Safety Meet Agreement er Status Change

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00589

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5227

On December 21, 2016, the Department of health and on Decemberr 15, 2016, the Department of public safety completed revisits to verify compliance iwth deficiencies issued pursuant to the October 27, 2017 survey not corrected at the time of the revisit. The most serious deficiency at the time of the revisit were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby corrections are required. As a result of our finding that the facility is not in substantial compliance, the Department imposed the Category 1 remedy of State monitoring, effective January 9, 2017.

In addition, regardless of any other remedies that may be imposed, the following must be imposed if the facility is not in substantial compliance by 3 months after the last day of the survey identifying non compliance. This, the CMS Region V Office concurs and is imposing the following remedy and has authroized this Department to notify the facility of the imposition:

Mandatory Denial of payment for new Medicare and Medicaid admissions (DPNA), effective January 27, 2017. (42 CFR 488.417 (b))

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP beginning January 27, 2017.

Refer to the CMS 2567 along with the POC for health, and CMS 2567b for both health and life safety code. Post Certification Revisit to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5694 3689

January 4, 2017

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

RE: Project Number S5227027

Dear Mr. Uselman:

On November 9, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 27, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On December 21, 2016, the Minnesota Department of Health and on December 15, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 27, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 8, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 27, 2016. The deficiencies not corrected are as follows:

- F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals
- F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following Category 1 remedy:

• State Monitoring effective January 9, 2017. (42 CFR 488.422)

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

Bayshore Residence & Rehabilitation Center January 4, 2017 Page 2

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 27, 2017. (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 27, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 27, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bayshore Residence & Rehab Ctr is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 27, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this 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

Bayshore Residence & Rehabilitation Center January 4, 2017
Page 3

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.

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 Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Teresa.Ament@state.mn.us

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Bayshore Residence & Rehabilitation Center January 4, 2017 Page 4

- 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 your signed plan of correction and your ePoC submission.

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 remedy 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 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 allegation of compliance and/or plan of correction.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services

Bayshore Residence & Rehabilitation Center January 4, 2017 Page 5

that your provider agreement be terminated by April 27, 2017 (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.

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

Sincerely,

Mark Meeth

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

Liliali. Illark.illeatil@state.illil.us

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

Enclosure(s)

RECEIVED

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

JAN 1 7 2017

PRINTED: 01/04/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION MN Dept of Health		E SURVEY PLETED
		245227	B. WING				∃ 21/2016
NAME OF		2-1022			TREET ADDRESS, CITY, STATE, ZIP CODE] 1 <i>2/1</i>	21/2010
NAME OF	PROVIDER OR SUPPLIER						•
BAYSHO	RE RESIDENCE & RE	EHAB CTR			601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs .	{F 0	00}			. "'
(F 431) SS=E	of this department of 12/21/16, to determ deficiencies issued exited on 10/27/16. regulations were de The facility's plan or as your allegation of Department's acceptottom of the first pube used as verificated. Upon receipt of an revisit of your facility validate that substate regulations has been your verification. 483.60(b), (d), (e) ELABEL/STORE DR The facility must entire a licensed pharmactor of records of receipt controlled drugs in accurate reconciliate records are in order controlled drugs is reconciled. Drugs and biological labeled in accordant professional principic appropriate accessinstructions, and the applicable.	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with DRUG RECORDS, UGS & BIOLOGICALS apploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be use with currently accepted les, and include the	√ β `\["		F 431- E Corrective Action: A. Insulin pens for residents R44 R89, R33, R18, R117, R162, R13, R14, R97, R100, R30, a R20, have been separated by appropriate barrier to prevent contamination for each device Each pen has opened date list the proper label, directions, as expiration dates. B. Humalog, Novolog, Lantus, as Novalin are now stored in sep baggies. Date of Completion: January 17, 2017 Corrective Actions as it applies to othe Residents: A. All insulin pens in the med can have been separated by approparate to prevent cross- contamination for each device Each pen has opened date list the proper label, directions, as expiration dates. B. All nurses and TMA's have received education expectation the Storage of Medication Pc C. All nurses and TMA's have received education expectation the Labeling of Medications.	R10, nd cross- e. ed, nd and parate 7 er arts priate e. ted, ind ons on plicy.	(X6) DATE

'efficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

If continuation sheet Page 1 of 8

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	-
		245227	B. WING		R 12/21/2016	
BAYSHO	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	East 1999.		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
	In accordance with facility must store al locked compartmen controls, and permit have access to the The facility must propermanently affixed controlled drugs listed Comprehensive Dru Control Act of 1976 abuse, except when package drug distributed quantity stored is mibe readily detected. This REQUIREMEN by: Based on observation review, the facility fawere labeled with direction opened date or expiresidents (R44, R89 R10, R13, R14, R97 insulin pens. Findings include: On 12/19/16, at 10:1-R44's Lantus insulin was not dated with odate, and was not la	State and Federal laws, the II drugs and biologicals in ts under proper temperature only authorized personnel to	{F 431	D. Facility has been in communiwith Pharmacy to assure compliance with labeling of delivered insulin pens. Date of Completion: January 17, 2017 Recurrence will be prevented by: A. Facility will perform storage/audits 4x's per week for 2 we then weekly audits for 4 months. B. Facility will perform 'Insulin Compliance' audits weekly formonths to assure proper storal labeling, and dating. C. Audit findings will be reported the QAPI Committee for reviand follow up recommendation. The QAPI Committee will determine when the audits madiscontinued. Responsible Person- Director of Nursian Compliance.	cart eks, ths. Pen or four ge, ed to ew ons.	
	director of nursing (At time.	ADON) verified findings at				

AND PLAN OF COHRECTION IDENTIFICATION NUMBER: A, BUILDING R 245227 B. WING 12/21/20	
	(0046
NAME OF PROVIDER OR SUPPLIER 245227 B. WING 12/21/20 STREET ADDRESS, CITY, STATE, ZIP CODE	/2016
1601 ST LOUIS AVENUE	
BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802	**************************************
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETION DATE
Continued From page 2 On 12/19/16, at 10:23 a.m. on Morning Light unit: -RB9's Novolog Flex insulin pen was in a baggle with her name on the baggle and on the pen, but lacked a label with directives for use, and an opened date or expiration date. Registered nurse (RN)-C verified findings, and stated the pens should be marked with the opened date or expiration date. On 12/19/16, at 10:28 a.m. on Park Breeze unit: -R33's Novolog insulin pen was not dated when opened or with an expiration date. On 12/20/16, at 4:16 p.m. the director of nursing (DON) stated insulin pen was not dated when opened. RN-E verified the findings. On 12/20/16, at 4:16 p.m. the director of nursing (DON) stated insulin pen was end labeled with directions for use on the pen or on the bag the pen was stored in. On 12/21/16, at 9:55 a.m. on Beachwalk unit: -R117's Lantus insulin pen was stored in a baggie with no directions for useR162's Lantus insulin pen was stored in a baggie with no directions for use. RN-C stated there were more pens today than were noted on 12/19/16, because some may have been stored in a bag with the Novolog pen with the directions for use of the Novolog. RN-C verified there was a risk for using the incorrect insulin pen, and giving the Lantus using the Novolog directions. On 12/21/16, at 10:10 a.m. on Morning Light unit: -R10's Lantus pen was stored in a baggie with Novolog insulin, with directions for the LantusR13's Lantus pen was not labeled with directions for use. RN-C verified the findings.	

PRINTED: 01/04/2017 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) MILL TIE	PLE CONSTRUCTION) <u>. 0938-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		TE SURVEY MPLETED	
l. 		245227	B. WING		i	R /21/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	/21/2016
BAYSHO	RE RESIDENCE & RI	EHAB CTR		1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RE	(X5) COMPLETION DATE
{F 431}	On 12/21/16, at 10:	12 a.m. on Harbor Light unit:	{F 431}			-
	was not labeled with					
	-R14's Novolog insu	15 a.m. on Park Breeze unit: Ilin pen was in a baggie directions for use, and lacked				
	an opened date or e insulin pen lacked a -R97's Lantus insuli	expiration date. R14's Lantus label and an opened date. In pen lacked a label. It is ast-acting insulin) lacked a				
	labelR18's Lantus insulii opened date. R18's	n pen lacked a label and an Humalog lacked a label for				
	opened date.	lin pen lacked a label and an				
	date.	ed a label and an opened d a label with directives for				
:	Licensed practical nu pens should be in the	urse (LPN)-D verified insulinger own baggie with labels for tion dates on them, LPN-D				
200	statéd the insulin per	ns should be dated. LPN-D ow when the pens were				
5	Storage of Medication Stored in the packagi	policy and procedure for ns directed drugs to be ng, containers or other n which they are received.				
	_abeling of Medication medication packaging madequately or impro	policy and procedure for in Containers directed any gor containers that are operly labeled shall be g pharmacy and labels for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
ì				R	
	245227	B. WING		12/21/2016	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHORE RESIDENCE & RE	EHAR CTR		1601 ST LOUIS AVENUE		
BATSTIONE RESIDENCE & AL	LIMBOTH		DULUTH, MN 55802		
PRÉFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION	
necessary informat and expiration date 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Presafe, sanitary and of the help prevent the of disease and infection Control The facility must es Program under white (1) Investigates, continuity in the facility; (2) Decides what preshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact will tra (3) The facility must hands after each dishand washing is indeprofessional practice (c) Linens	tainers should include all ion including directions for use. I CONTROL, PREVENT Itablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, on an individual resident; and ord of incidents and corrective fections. I ad of Infection ion Control Program esident needs isolation to of infection, the facility must asse or infected skin lesions with residents or their food, if ansmit the disease. I require staff to wash their rect resident contact for which licated by accepted	{F 4		e use. r l vided 7 cion on	

STATI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245227	B. WING	22 ' 1 min m		R	
ĺ	ME OF PROVIDER OR SUPPLIER YSHORE RESIDENCE & F			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		2/21/2016	
PRI	EFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO	DULD BE	(X5) COMPLETION DATE	
{F •	Infection. This REQUIREME by: Based on observer review, the facility hygiene practices of toileting cares for 1 observed during in Findings include: R128's Admission indicated R128 had incontinence. R128's admission indicated R128 had moderated skills for daily decis assistance of 2 stated R128's care plan in was frequently incomand was at risk for R128's care plan difficontinence every perineum, monitor finfection. On 12/20/16, at 10: his bathroom, put of remove R128's incompared in the control of the contro	as to prevent the spread of NT is not met as evidenced ation, interview, and document failed to ensure proper hand were maintained during of 3 residents (R128) continent or toileting cares. Record printed 12/20/16, it a diagnosis of urinary MDS dated 10/4/16, indicated the impairment for cognitive ion-making, and required	{F 44	C. DON, ADON, Education and other designees will or least five on-the-spot demonstrations of staff handwashing/gloving proweek for four weeks, then weekly audits for 4 month D. DON, ADON, Education and other designees will properties handwashing and glove used at a present the properties of the prop	cedure per once s. Nurse erform se audits s, then s. orted to eview ations.		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
		245227	B. WING			i	R /21/2016
	PROVIDER OR SUPPLIER ORE RESIDENCE & RI				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	1 12/	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	NA-P took a clean in R128's room, retrout clean gloves on urine with a cleansi and as R128 stood, stool with the wipes the garbage. NA-P R128's pants and hould wash his hand without doing hand out of the room, the opened the room do then opened the dogarbage bag into the her hands. On 12/20/16, at 10: sanitized her hands after toileting, and a garbage. NA-P verificative her hands after toileting, and a garbage. NA-P verificative glove chands after toileting, and should be tween glove chands between glove chands between glove stated staff should oresident, remove glown to the complex of the complex	ge 6 ncontinent brief from a drawer urned to the bathroom, and . NA-P cleansed R128's leg of ng wipe, took out clean wipes NA-P wiped his buttocks of , and disposed of them into adjusted the brief, pulled up elped him to the sink so he ds. NA-P removed her gloves hygiene, pulled the wheelchair n tied up the garbage bag, bor, and left the room. NA-P or to the utility room, put the e garbage, and then sanitized 18 a.m. NA-P stated she when entering R128's room, fter throwing away the ied she had not sanitized ges, touched clean things ould have cleaned her hands ges and after removing 3 p.m. the director of nursing should wash or sanitize e use, after visiting a exposed to body fluids. DON lean hands, glove, assist oves after peri care, wash sh cares, remove gloves and had before leaving the room. policy and procedure for Hygiene directed staff to ids before and after direct its, before moving from a site to a clean body site	{F 4.	41}			

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	TIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			R	
WAME OF	PROVIDER OR SUPPLIER	243221					
INAME OF	PHOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE			
BAYSHO	RE RESIDENCE & RE	HAB CTR					
				DULUTH, MN 55802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
{F 441}			{F 44	11}			
	during resident care bodily fluids, and af	e, after contact with blood or ter removing gloves.					
					,	·	
						::	
			£				
				,			
And the control of th							
and the second							
t nedgy							
1.5		!					

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	ISIT
	B. Wing		Y2	12/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BAYSHORE RESIDENCE & REHAB CTR		1601 ST LOUIS AVENUE			
		DULUTH, MN 55802			

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

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0225	Correction	ID Prefix F02	226	Correction	ID Prefix	F0242		Correction
Reg. #	483.13(c)(1)(ii)-(- (4)	iii), (c)(2) Completed	Reg. #	.13(c)	Completed	Reg. #	483.15(b)		Completed
LSC		12/08/2016	LSC		12/08/2016	LSC			12/08/2016
ID Prefix	F0282	Correction	ID Prefix F03	315	Correction	ID Prefix	F0353		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	.25(d)	Completed	Reg.#	483.30(a)		Completed
LSC		12/08/2016	LSC		12/08/2016	LSC			12/08/2016
ID Prefix	F0465	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.70(h)	Completed	Reg. #		Completed	Reg. #			Completed
LSC		12/08/2016	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC			LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) TA/mm	DATE 01/04/2017	SIGNATURE OF	SURVEYOR 34983			DATE 12/15	5/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/27/2016			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					s 🗆 NO	

POST-CERTIFICATION REVISIT REPORT

			_				
	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01			DATE OF REVI	SIT		
245227 _{Y1}	B. Wing	,	Y2	12/15/2016	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE					
BAYSHORE RESIDENCE & RE	EHAB CTR	1601 ST LOUIS AVENUE					
		DULUTH, MN 55802					
This report is completed by a q	ualified State surveyor for the Medicare,	Medicaid and/or Clinical Laboratory Improveme	ent A	mendments			

program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4		DATE Y5	ITEM Y4	DATE Y5	ITEM Y4		DATE Y5	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg. #	NFPA 101	Completed	Reg. #	101 Completed	Reg. #		Completed	
LSC	K0018	12/08/2016	LSC K0056	12/08/2016	LSC			
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed	
LSC			LSC		LSC			
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed	
LSC			LSC		LSC _			
ID Prefix		Correction	ID Prefix	Correction	ID Prefix _		Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed	
LSC			LSC		LSC _			
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed	
LSC			LSC		LSC _			
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/mm	DATE 01/04/2017	SIGNATURE OF SURVEYOR 12/15/201	16	DATE 12/15	5/2016	
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		DATE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/25/2016				R ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567)		EA OULIENTO	s 🗆 no	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on January 20, 2017 January 20, 2017

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

Re: Project # S5227027

Dear Mr. Uselman:

On December 21, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 27, 2016 with orders received by you electronically on January 20, 2017.

State licensing orders issued pursuant to the last survey completed on October 27, 2016 and found corrected at the time of this December 21, 2016 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on October 27, 2016, found not corrected at the time of this December 21, 2016 revisit and subject to penalty assessment are as follows:

- 21375 MN Rule 4658.0800 Subp. 1- Infection Control; Program \$300.00
- 21610 MN Rule 4658.1340 Subp. 1- Medicine Cabinet And Preparation Area; storage \$300.00

The details of the violations noted at the time of this revisit completed on December 21, 2016 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, <u>you will be assessed an amount of</u> \$600.00 per day beginning on the day you receive this notice.

Bayshore Residence & Rehabilitation Center January 20, 2017 Page 2

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, 11 E Superior St #290, Duluth, Mn 55802.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

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

PRINTED: 01/04/2017 FORM APPROVED

Minnesota Department of Health

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA TON NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMPI	
				A. BOILDING.		R	1
		00589		B. WING			1/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR		OUIS AVEN MN 55802	UE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments			{2 000}			
	****ATTE	NTION*****					
	NH LICENSING CORRECTION ORDER						
	In accordance with 144A.10, this correpursuant to a surve found that the deficiency are not corrected shall with a schedule of the Minnesota Dep	ction order has ey. If, upon reir siency or deficie ected, a fine for be assessed ir fines promulga	been issued aspection, it is encies cited reach violation accordance ted by rule of				
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.						
	You may request a that may result from orders provided that the Department with notice of assessment.	n non-compliar at a written requ hin 15 days of	nce with these uest is made to receipt of a				
	INITIAL COMMENTAN onsite follow-up 12/21/2016. During determined that the 2 - 1375, 2 - 1610, These uncorrected and will be reviewe uncorrected orders	visit was comp this onsite visite following corre- were not corre- orders will rem d at the next or	t it was ections orders: cted. nain in effect nsite visit. Also		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. I to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00589	B. WING		R 12/21/2016	
					12/21/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S L OUIS AVEN	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAR CTR	MN 55802	0 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
{2 000}	Continued From pa	ge 1	{2 000}			
	penalty assessmen			The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Method Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SUBMIT A PLAN OF CORR	Tag." the tute/rule ies" ply" nis s which after the s veyors d of DING OF THIS O DN FOR	
				STATUTES/RULES.		
{21375}	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	{21375}			
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.				
	by:	ent is not met as evidenced on, interview, and document				

Minnesota Department of Health

STATE FORM 99ZW12 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		D. `	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00589	В.	WING		12/2	₹ 1/ 2016
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	HAB CTR 16	REET ADDRE 01 ST LOU JLUTH, MN	JIS AVENU	TATE, ZIP CODE I E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{21375}	review, the facility	ailed to ensure proper havere maintained during of 3 residents (R128) continent or toileting care Record printed 12/20/16, a diagnosis of urinary MDS dated 10/4/16, indicate impairment for cognitivition-making, and required	and es. cated ve d I R128 dder ry his of 128 to n the ief o the leg of wipes s of into d up	21375}			

Minnesota Department of Health

STATE FORM Y9ZW12 If continuation sheet 3 of 7

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
					R	
		00589	B. WING		12/2	1/2016
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	-HAB CTR	OUIS AVENI MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETE DATE
{21375}	Continued From pa	ge 3	{21375}			
	out of the room, the opened the room de then opened the do	hygiene, pulled the wheelchair en tied up the garbage bag, oor, and left the room. NA-P or to the utility room, put the se garbage,and then sanitized				
	sanitized her hands after toileting, and a garbage. NA-P veri between glove char and clothes, and sh	18 a.m. NA-P stated she when entering R128's room, after throwing away the fied she had not sanitized nges, touched clean things nould have cleaned her hands nges and after removing				
	On 12/20/16, at 4:06 p.m. the director of nursing (DON) verified staff should wash or sanitize hands between glove use, after visiting a resident, and when exposed to body fluids. DON stated staff should clean hands, glove, assist resident, remove gloves after peri care, wash hands, re-glove, finish cares, remove gloves and sanitize or wash hands before leaving the room.					
	Handwashing/Hand sanitize or wash ha contact with resider contaminated body during resident care	r policy and procedure for d Hygiene directed staff to nds before and after direct nts, before moving from a site to a clean body site e, after contact with blood or ter removing gloves.				
{21610}	MN Rule 4658.1340 and Preparation Are	O Subp. 1 Medicine Cabinet ea;Storage	{21610}			
	must store all drugs	e of drugs. A nursing home in locked compartments erature controls, and permit				

Minnesota Department of Health

STATE FORM 992W12 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00589	B. WING			R 21/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR	LOUIS AVENI I, MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{21610}	only authorized nursaccess to the keys. This MN Requirements by: Based on observatireview, the facility fawere labeled with dopened date or expresidents (R44, R85 R10, R13, R14, R9 insulin pens. Findings include: On 12/19/16, at 10:-R44's Lantus insuliwas not dated with date, and was not labeled with date, and was not labeled with director of nursing (that time. On 12/19/16, at 10:-R89's Novolog Flewith her name on the lacked a label with opened date or exp (RN)-C verified find should be marked wexpiration date. On 12/19/16, at 10:-R33's Novolog insuppened or with an expiration date.	sing personnel to have ent is not met as evidenced on, interview, and document ailed to ensure insulin pens irections for use and/or iration date for 13 of 19 9, R33, R18, R117, R162, 7, R100, R30, R20) who used 13 a.m. on Harbor Light unit: in (long-acting insulin) pen opened date or expiration abeled with directions for use. st-acting insulin) insulin pen in directions for use. Assistant ADON) verified findings at 23 a.m. on Morning Light unit ix insulin pen was in a baggie he baggie and on the pen, but directives for use, and an iration date. Registered nurse ings, and stated the pens with the opened date or :28 a.m. on Park Breeze unit: ulin pen was not dated when expiration date. sulin pen was not dated when				

Minnesota Department of Health

STATE FORM 992W12 If continuation sheet 5 of 7

NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR B. WING	-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
BAYSHORE RESIDENCE & REHAB CTR 1601 ST LOUIS AVENUE DULUTH, MN 55802			00589	B. WING			
BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802	NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
	BAYSHO	ORE RESIDENCE & RE	HAB CTR		JE		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
(21610) Continued From page 5 ((DON)) stated insulin pens needed to be marked with an opened date, expiration date, and labeled with directions for use on the pen or on the bag the pen was stored in. On 12/21/16, at 9:55 a.m. on Beachwalk unit: - R117's Lantus insulin pen was stored in a baggie with no directions for use R162's Lantus insulin pen was stored in a baggie with no directions for use R162's Lantus insulin pen was stored in a baggie with no directions for use. RN-C stated there were more pens today than were noted on 12/19/16, because some may have been stored in a bag with the Novolog pen with the directions for use of the Novolog, RN-C verified there was a risk for using the incorrect insulin pen, and giving the Lantus using the Novolog directions. On 12/21/16, at 10:10 a.m. on Morning Light unit: - R10's Lantus pen was stored in a baggie with Novolog insulin, with directions for the Novolog and no directions for the LantusR13's Lantus pen was not labeled with directions for the R14's Humalog insulin pen was in a baggie and was not labeled with directions for use. On 12/21/16, at 10:12 a.m. on Park Breeze unit: -R14's Novolog insulin pen was in a baggie without a label with directions for use, and lacked an opened date or expiration date. R14's Lantus insulin pen lacked a labelR10's Novalin R (tast-acting insulin) lacked a labelR10's Novalin R (tast-acting insulin) lacked a labelR10's Lantus insulin pen lacked a label and an opened dateR18's Lantus insulin pen lacked a label and an opened dateR18's Lantus insulin pen lacked a label and an opened date.	{21610}	(DON) stated insuli with an opened date with directions for u the pen was stored On 12/21/16, at 9:5 - R117's Lantus ins baggie with no directions and there were more periodically because in a bag with the Note for use of the Novorisk for using the interest of the Novorisk for using the Nov	n pens needed to be marked e, expiration date, and labeled ise on the pen or on the bag in. 5 a.m. on Beachwalk unit: ulin pen was stored in a ctions for use. ulin pen was stored in a ctions for use. RN-C stated ens today than were noted on some may have been stored evolog pen with the directions log. RN-C verified there was a correct insulin pen, and giving e Novolog directions. 10 a.m. on Morning Light unit: was stored in a baggie with h directions for the Novolog or the Lantus. was not labeled with directions ed the findings. 12 a.m. on Harbor Light unit: sulin pen was in a baggie and h directions for use. 15 a.m. on Park Breeze unit: ulin pen was in a baggie directions for use, and lacked expiration date. R14's Lantus a label and an opened date. in pen lacked a label. (fast-acting insulin) lacked a				

Minnesota Department of Health

STATE FORM 992W12 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		:D. `	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00589	B.	. WING		F 12/2	R 21/2016
	PROVIDER OR SUPPLIER DRE RESIDENCE & RE	HAB CTR	REET ADDRE	JIS AVENU	TATE, ZIP CODE JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIOI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{21610}	opened dateR30's Novolog lack dateR20's Lantus lacke use. R20's Novolog Licensed practical repens should be in the use and open/expiristated the insulin perstated she did not knopened. The undated facility Storage of Medicatistored in the packard dispensing systems. The undated facility Labeling of Medication packaginadequately or importer the insuling control in the issuindividual drug control.	ked a label and an open ed a label with directives lacked a label. hurse (LPN)-D verified in heir own baggie with lab ration dates on them. LP ens should be dated. LP know when the pens were policy and procedure for ions directed drugs to be ging, containers or other is in which they are received policy and procedure for ion Containers directed ing or containers that are properly labeled shall be latiners should include all ion including directions for the latiners should include all ion including directions for the latiners should include all ion including directions for the latiners should include all ion including directions for the latiners and labels the latiners should include all ion including directions for the latiners and latiners are latiners.	ed s for nsulin lels for	21610}			

6899

Minnesota Department of Health STATE FORM

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: Y9ZW

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY A	AGENCY	1	Facility ID: 00589
MEDICARE/MEDICAID PROVIDER (L1) 245227 2.STATE VENDOR OR MEDICAID NO	3. NAME AND ADDRESS OF FACILITY (L3) BAYSHORE RESIDENCE & REHAB CTR (L4) 1601 ST LOUIS AVENUE				4. TYPE OF ACTION: 1. Initial 3. Termination	2 (L8) 2. Recertification 4. CHOW		
(L2) 1821433426	(L5) DULUTH, MN			(L6) 55802		5. Validation	6. Complaint	
5. EFFECTIVE DATE CHANGE OF O' (L9) 07/01/2013	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			02 (L7) 13 PTIP 22 CLIA		7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 1072 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	27/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	:	FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 139 (L37) (L38)	19 SNF (L39)	X B. Not in Com Requirements : ICF (L42)	nce With equirements Based On: Acceptable POC hipliance with Program and/or Applied Waiv IID (L43)	n	2. T 3. 2 4. 7. 5. L * Code:	echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code B*	E-Following Requirements: 6. Scope of Serv 7. Medical Direct 8. Patient Room 9. Beds/Room (L12) (L15)	ctor
	· 							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APPROVAL Date:			
Kathie Killoran, HFI	12/12/2016 (L19)			Mark Weath, Enforcement Specialist 12/19/2016 (L20)				
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OF	R SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILE 1. Facility is Eligible to P 2. Facility is not Eligible	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	ENT 24. LTC AGREEMENT		26. TERMIN	JATION ACTION:	((L30)		
OF PARTICIPATION 01/22/1979	DATE ENDING DATE		VOLUNTARY 01-Merger, Cl			TARY leet Health/Safety		
(L24)	(L41)		(L25)			tion W/ Reimburseme	nt 06-Fail to M	Ieet Agreement
5. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44)						oluntary Termination on for Withdrawal	OTHER 07-Provider 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	g 45					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	(L45)		30. REMARK	.s		
						-		
	03001	(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	ГЕ				
	(L32)			(L33)	DETERMI	NATION APPRO	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1494

November 10, 2016

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

RE: Project Number S5227027

Dear Mr. Uselman:

On October 27, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

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 Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Email: <u>Teresa.Ament@state.mn.us</u>

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 6, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 6, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by January 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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 Inspection 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,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

NOV 2 & 2016

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

PRINTED: 11/09/2016 **FORM APPROVED** OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E .	DING			(X3) DATE SURVEY COMPLETED	
		245227	B, WING			10.	27/2016	
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	EHAB CTR	:	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	1 10/	21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225 SS=E	you allegation of co department's accept bottom of the first pube used as verificated. Upon receipt of an arevisit of your facility validate that substate gulations has been your verification. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REFALLEGATIONS/INETALLEG	correction (POC) will serve as mpliance upon the stance. Your signature at the age of the CMS-2567 form will ion of compliance. acceptable POC, an onsite y may be conducted to ntial compliance with the en attained in accordance with PORT	F 2		F 225- D Corrective Action: A. Facility visited with R130, F R61, and R76. The safety of four residents has been assur	all red.		
ABORATORY	The facility must en involving mistreatme including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce	ies. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the	1 JA		Residents: A. The Abuse Prevention Plan reviewed. Facility staff mer were re-educated about the A Prevention Plan and the defi of Immediate Reporting to Administrator/State Agency The education occurred at the Staff Meetings completed the of 11-28-16.	nbers Abuse nition (SA). ne All ne week	(X6) DATE	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED 10/27/2016		
		245227	B. WING				
	PROVIDER OR SUPPLIER PRE RESIDENCE & R	EHAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	prevent further pote investigation is in pote investigation is in pote investigation is in potential to the administrator representative and with State law (incle certification agency incident, and if the appropriate correct. This REQUIREME by: Based on interview facility failed to import and a facility failed to import and and are incident of mistreat agency; an incident and was submitted the SA. R130's Admission that included need and reduced mobil Data Set (MDS) day was cognitively into wheelchair for mobil R130's care plantotents.	bughly investigated, and must ential abuse while the progress. Investigations must be reported to or his designated to other officials in accordance uding to the State survey and () within 5 working days of the alleged violation is verified tive action must be taken. In and document review, the nediately report to the State tial allegations of mistreatment residents (R130, R30, R61, abuse. Immediately report an alleged the treport occurred on 3/6/16, and 3/7/16 (time unknown) to the state treport occurred on 3/6/16, and 3/7/16 (time unknown) to the state of the state	F 2	225	Pate of Completion: December 8, 201 Recurrence will be prevented by: A. Facility Staff received educati related to the Abuse Preventice Plan, the definition of 'immediate reporting' the initial report to Administrator/SA at the All S Meetings completed the week 11-28-16. B. Facility will perform audits 42 per week for 2 weeks, then we audits for 4 weeks, then mont audits for 3 months. Findings be reported to the QAPI Comfor review and follow up recommendations. The QAPI Committee will determine whe audits may be discontinued. Responsible Person: Administrator or Designee	taff of x's eekly hly swill mittee	

PRINTED: 11/09/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	COMPLETED			
		245227	B. WING			10/27/2016		
	PROVIDER OR SUPPLIEF			1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS, AVENUE OULUTH, MN 55802			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	to physical impairs On 10/24/16, at 3 physically abused R130 stated he w another resident. nothing was done sign across his ro According to the f State Agency (SA stomach by anoth Progress notes w R107 made multi room that shift, ar approached tighte indicated R107 w room causing R1 On 10/26/16, at 1 stated she wasn't incident involving got the informatio was reportable, a reported to the SA On 10/27/16, at 8 like how the incid he felt as if he wa stated R107 wou progress and R1 stated staff would was targeting hin him after the incid didn't know what at him, but at the stated change w wasn't until R107	ments and low mobility. 52 p.m. R130 stated he was by another resident (R107). as punched in the stomach by R130 stated he told staff and except putting a mesh stop om door. acility's incident report to the), R130 was lightly hit in the ter resident, R107, on 3/6/16. Which is the incident report indicated one attempts to enter R130's and at one point in time ening his fists. The note further as hovering around R130's 30 some concern. 2:33 p.m. social worker (SW)-A immediately notified of the R130. SW-A states when she on and reviewed it, she knew it and the incident was then		225				

	ATEMENT OF DEFICIENCIES DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILC		(X3) DATE SURVEY COMPLETED		
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIER			16	REET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	The facility did not incident of mistrea the SA. An incider 9/21/16; an incide 9/23/16 (time unking 16/23/16 (time unking 16/23/16) (time	as a whole new person. Immediately report an alleged atment (neglect) against R30 to not occurred the evening of not report was submitted on nown). Record identified a diagnosis of squarterly MDS dated 8/30/16, scognitively intact, and was upon staff for toileting. Lated 3/10/16, indicated R30 colostomy. The goal indicated do be maintained and the nain patent/functional through late. The care plan also indicated or injury/abuse from others due of the sain assistant refused to empty goals as stated the staff adoor after the refusal. R30 light R30 stated another staff person	F2	225			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING			10/27/2016		
	PROVIDER OR SUPPLIER PRE RESIDENCE & R	•		10	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE OLLUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	incident of mistrea An incident occurrincident report was unknown). R61's Admission r Alzheimer's diseas 7/27/16, indicated cognition, and req maneuvering of lir assistance) with w corridor and on the R61 used a walke R61's care plan do the potential to wain search of her own distract and reories afe areas. The cown was at risk for injudiagnosis of demender risk of wander On 9/3/16, a behas slammed R61's hawas in his room. Find his call light to cal replied "whatever" 9/7/16, a progress indicated that on sanother resident's redirected, the oth R61's hand. R61 the physician was	immediately report an alleged the the sale and on 9/3/16, at 2030; an as submitted on 9/6/16 (time) ecord identified a diagnosis of se. R61's quarterly MDS dated R61 had severely impaired uired limited assistance (guided and or other non-weight bearing ralking in her room, in the equit. The MDS also indicated r. atted 8/2/16, indicated R61 has ander into other people's rooms who. Staff were directed to not the resident as needed to are plan also identified R 61 irry/abuse from others due to her entia, her cognitive deficits, and		225				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/:	27/2016	
	PROVIDER OR SUPPLIER RE RESIDENCE & F			10	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE OLLUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	was nothing to ind administrator were incident On 10/26/16, at 1: stated staff though abuse. The admin notes the next day didn't want it to be facility reported their their minds. The facility did not of mistreatment as 9/16/16, in an atte R76 fell from her vabrasion to her far reported to the SA R76's Admission Fincluded Parkinso and low back pain 9/27/16, indicated cognition, and requed mobility, transunit, dressing, tolk MDS further indicassessment perior R76's care plan dakeep the call light care plan also ide injury/abuse from	2:33 p.m. SW-A confirmed there icated the DON or enotified at the time of the 39 p.m. the administrator at this was an accident and not istrator stated he reviewed during morning meeting and a question in the future, so the eincident while it was still fresh immediately report an incident gainst R76 to the SA. On mpt to reach for her call light, wheelchair and received an entity and incident was not a until 9/20/16 (time unknown). Record identified diagnoses that in's disease, vascular dementia, R76's quarterly MDS dated R76 had moderately impaired uired extensive assistance with iters, locomotion on and off the enting and personal hygiene. The lated R76 did not walk during the	F;	225				
	was found on the	floor on 9/16/16, and the eported to the SA until 9/20/16.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245227	B. WING		10	/27/2016		
	PROVIDER OR SUPPLIER RE RESIDENCE & RI	EHAB CTR		STREET ADDRESS, CITY, STATE, ZIP 1601 ST LOUIS AVENUE DULUTH, MN 55802	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 225	stated he believed immediately becaut to be reported as Finjury. The adminishave been reported reach, thus the car On 10/26/16, at 1:1 (DON) stated if the DON or the adminion On 10/26/16, at 1:3 stated he expects the reportable incident hours. The administration stated he or SW-A, regarding abuse prostated he or SW-A, regarding abuse prostated he or SW-A determine if an everal administrator state same way as he is exceed 24 hours. The administrator state incident. The administrator state on abuse prohibition. The facility Abuse directed staff to rejimmediately throug report systems. The internal investig	89 p.m. the administrator this incident was not reported se staff did not think it needed 876 did not sustain a major trator also stated it should d as the call light was not within e plan was not being followed. 86 p.m. the director of nursing re is an incident either the strator are called by staff. 89 p.m. the administrator to be notified of any potential immediately, not to exceed 24 strator stated staff will call him, who are the facility's contacts rohibition. The administrator are often the staff that ent is reportable. The d the SA should be notified the notified: immediately not to The administrator added the ade as soon as is practicable. Stated leadership report they are made aware of an inistrator stated if an incident of nent occurred on a Saturday out should be made then. The d they educate staff annually	F 2	25				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIER RE RESIDENCE & RE	EHAB CTR		16	FREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	director or DON, an in the building, staff supervisor, nurse m time of suspicion. T takes place but lack timeframe for that m internal investigatio immediately. 483.13(c) DEVELO ABUSE/NEGLECT	ninistrator, social service and if these individuals are not are to report to the nursing nanager or team leader at the the policy directed reporting sed specification of the eporting. The policy indicated n of suspect abuse begins P/IMPLMENT , ETC POLICIES		225	F 226- D Corrective Action: A. R130, R30, R61, and R76. T safety of all residents has bee		
	policies and proced mistreatment, negle and misappropriation. This REQUIREMENT by: Based on interview facility failed to deverable prohibition policy with notification to the Sallegations of mistre investigations for 4 (R130, R30, R61, Findings include: The facility Abuse Findings include:	evelop and implement written dures that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced of and document review, the elop and implement an abuse hich required immediate tate Agency (SA) for eatment prior to conducting of 4 residents residents (R76) reviewed for abuse. Prohibition Plan dated 5/20/16, fort suspected maltreatment the either the internal or external expolicy directed staff to begin atton immediately. The policy for report suspected abuse ministrator, social service			Corrective Actions as it applies to oth Residents: A. The Abuse Prevention Plan of reviewed and revised. All Fastaff were re-educated about Abuse Prevention Plan, specidentifying abuse and the defortimediate reporting to Administrator/SA. The educoccurred at the All Staff Medicompleted the week of 11-28. Date of Completion: December 8, 20. Recurrence will be prevented by: A. Facility Staff received educated to the Abuse Prevent Plan, how to identify abuse, definition of 'immediate reput to the Administrator/SA at the Staff Meetings completed the of 11-28-16.	vas acility the ifically finition eation etings 3-16. 16 tion ion and the orting' ne All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245227	B. WING		10/	27/2016
	ROVIDER OR SUPPLIER	EHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
	in the building, staff supervisor, nurse in time of suspicion. Takes place but lack timeframe for that internal investigation immediately. The facility did not incident of mistreat agency; an incident and was submitted the SA. R130's Admission International that included need and reduced mobilid Data Set (MDS) dawas cognitively into wheelchair for mobilid Data Set (MDS) dawas cognitively into w	and if these individuals are not are to report to the nursing manager or team leader at the The policy directed reporting and specification of the reporting. The policy indicated in of suspect abuse begins mediately report an alleged ment against R130 to the state are report occurred on 3/6/16, on 3/7/16 (time unknown) to record identified diagnoses for assist with personal care ty. R130's quarterly Minimum ted 9/29/16, indicated R130 and used a walker and a illity devices. The policy directed reporting at the state of	F 2	B. Facility will perform aud per week for 2 weeks, then audits for 4 weeks, then audits for 3 months. Fin be reported to the QAPI for review and follow up recommendations. The Committee will determine audits may be discontinuated Responsible Person: Administrated Administrated Responsible Person: Administrated	en weekly monthly dings will Committee QAPI e when the ed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIER	EHAB CTR		1601	EET ADDRESS, CITY, STATE, ZIP CODE I ST LOUIS AVENUE LUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	tightening his fists. R107 was hovering R130 some concer On 10/26/16, at 12 stated she wasn't i incident involving F got the information was reportable, an reported to the SA On 10/27/16, at 8:8 like how the incide he felt as if he was stated R107 would progress and R107 stated staff would was targeting him. him after the incided didn't know what hat him, but at the stated change was wasn't until R107's that he stopped ta felt like a R107 was The facility did not incident of mistreathe SA. An incider 9/21/16; an incider 9/23/16 (time unknown R30's Admission F quadriplegia. R30' indicated R30 was totally dependent R30's care plan dispersion of the R30's care plan dispersion of t	The note further indicated g around R130's room causing rn. :33 p.m. social worker (SW)-A mmediately notified of the R130. SW-A states when she and reviewed it, she knew it d the incident was then :54 a.m. R130 stated he didn't nt was handled. R130 stated doing something wrong. R130 stated in the hall and block his reduced with two was doing something wrong. R130 close his door if they felt R107 R130 stated R107 targeted ent too. R130 stated R107 e was doing, so he wasn't mad staff for not addressing it. R130 stated root in the reduced in		226			

DEFICIENCIES PRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	245227	B. WING			10/	27/2016	
			160	1 ST LOUIS AVENUE			
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE	
O's dignity would reme next review day of the next reported it to next report day of the next report was a next re	d be maintained and the rain patent/functional through te. The care plan also indicated r injury/abuse from others due. D:05 a.m., R30 stated there was sing assistant refused to empty. R30 also stated the staff door after the refusal. R30 ave his "tool" on his hand, so he door handle, and his call light R30 stated another staff person assist him. Cacility's investigative report, res on 9/21/16, a nursing used to assist R30 with stomy bag and closed R30's hind him as he left. C16 p.m. the DON stated he dent on 9/22/16, at 10:30 a.m. the State Agency by 10:30 a.m. at immediately report an alleged atment against R61 to the SA. red on 9/3/16, at 2030; an s submitted on 9/6/16 (time	F2	226				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR O's dignity would comy would remed to was at risk for mobility deficits 10/25/16, at 10 me when a nurcolostomy bag rson closed the didn't had a control of reach. The sout of the incider of mistreating of the sout of the incider of the incider of mistreating of the sout of the incider of mistreating of the sout of the incider of mistreating of the sout of the incider of mistreating of the incider of mist	IDENTIFICATION NUMBER: 245227 IDER OR SUPPLIER RESIDENCE & REHAB CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 10 O's dignity would be maintained and the comy would remain patent/functional through enext review date. The care plan also indicated 0 was at risk for injury/abuse from others due mobility deficits. 10/25/16, at 10:05 a.m., R30 stated there was time when a nursing assistant refused to empty colostomy bag. R30 also stated the staff reson closed the door after the refusal. R30 tated he didn't have his "tool" on his hand, so he coldn't open the door handle, and his call light is out of reach. R30 stated another staff person me soon after to assist him. Cording to the facility's investigative report, ring evening cares on 9/21/16, a nursing sistant (NA) refused to assist R30 with aptying R30's ostomy bag and closed R30's droom door behind him as he left. 10/26/16, at 1:16 p.m. the DON stated he armed of the incident on 9/22/16, at 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. 9/23/16. The facility did not immediately report an alleged dident of mistreatment against R61 to the SA. incident occurred on 9/3/16, at 2030; an ident report was submitted on 9/6/16 (time)	IDENTIFICATION NUMBER: 245227 B. WING FIDER OR SUPPLIER RESIDENCE & REHAB CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIT TAG O'S dignity would be maintained and the comy would remain patent/functional through extreview date. The care plan also indicated one was at risk for injury/abuse from others due mobility deficits. 10/25/16, at 10:05 a.m., R30 stated there was time when a nursing assistant refused to empty colostomy bag. R30 also stated the staff reson closed the door after the refusal. R30 stated he didn't have his "tool" on his hand, so he coldn't have his "tool" on his hand, so he coldn't open the door handle, and his call light is out of reach. R30 stated another staff person me soon after to assist him. Coording to the facility's investigative report, ring evening cares on 9/21/16, a nursing sistant (NA) refused to assist R30 with aptying R30's ostomy bag and closed R30's droom door behind him as he left. 10/26/16, at 1:16 p.m. the DON stated he arroad of the incident on 9/22/16, at 10:30 a.m. dreported it to the State Agency by 10:30	TIDER OR SUPPLIER RESIDENCE & REHAB CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) TIDING INTINUED From page 10 O's dignity would be maintained and the corny would remain patent/functional through enext review date. The care plan also indicated was at risk for injury/abuse from others due mobility deficits. 10/25/16, at 10:05 a.m., R30 stated there was me when a nursing assistant refused to empty colostomy bag. R30 also stated the staff rson closed the door after the refusal. R30 ted he didn't have his "tool" on his hand, so he clidn't open the door handle, and his call light is out of reach. R30 stated another staff person me soon after to assist him. cording to the facility's investigative report, ring evening cares on 9/21/16, a nursing sistant (NA) refused to assist R30 with pytying R30's ostomy bag and closed R30's droom door behind him as he left. 10/26/16, at 1:16 p.m. the DON stated he includent on 9/22/16, at 10:30 a.m. dreported it to the State Agency by 10:30 a.m. 9/23/16. e facility did not immediately report an alleged ident of mistreatment against R61 to the SA. incident occurred on 9/3/16, at 2030; an ident report was submitted on 9/6/16 (time known). It's Admission record identified a diagnosis of theimer's disease. R61's quarterly MDS dated 27/16, indicated R61 had severely impaired gnition, and required limited assistance (guided aneuvering of limbs or other non-weight bearing sistance) with walking in her room, in the	DENTIFICATION NUMBER: 245227 DEER OR SUPPLIER RESIDENCE & REHAB CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PHECEDED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION) Intinued From page 10 O's dignity would be maintained and the orny would remain patent/functional through a next review date. The care plan also indicated 0 was at risk for injury/abuse from others due mobility deficits. 10/25/16, at 10:05 a.m., R30 stated there was me when a nursing assistant refused to empty colostomy bag. R30 also stated the staff son closed the door after the refusal. R30 ted he didn't have his "tool" on his hand, so he ulfort open the door handle, and his call light s out of reach. R30 stated another staff person me soon after to assist him. cording to the facility's investigative report, ring evening cares on 9/21/16, a nursing sistant (NA) refused to assist R30 with ptyting R30's ostomy bag and closed R30's droom door behind him as he left. 10/26/16, at 1:16 p.m. the DON stated he rined of the incident on 9/22/16, at 10:30 a.m. of reported it to the State Agency by 10:30 a.m. of rep	DERICTION 245227 B. WING TIDER OR SUPPLIER RESIDENCE & REHAB CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST as EPRECEDED BY PULL REQULATORY OR LSC IDENTIFYING INFORMATION) DISTINUTE OF THE APPROPRIATE OF DEFICIENCIES (EACH DEFICIENCY MUST as EPRECEDED BY PULL REQULATORY OR LSC IDENTIFYING INFORMATION) Thit induced From page 10 O's dignity would be maintained and the orny would remain patentifunctional through next review date. The care plan also indicated owas at risk for injury/abuse from others due mobility deficits. 10/25/16, at 10:05 a.m., R30 stated there was me when a nursing assistant refused to empty colostomy bag, R30 also stated the staff rson closed the door after the refusal. R30 ted he dight have his "bol" on his hand, so he uldn't open the door handle, and his call light so cut of reach. R30 stated another staff person me soon after to assist him. cording to the facility's investigative report, ring evening cares on 9/21/16, a nursing sistant (NA) refused to assist R30 with ptying R30's ostomy bag and closed R30's droom door behind him as he left. 10/26/16, at 1:16 p.m. the DON stated he inved of the incident on 9/22/16, at 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported it to the State Agency by 10:30 a.m. dreported	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245227	B. WING			10/2	7/2016
	PROVIDER OR SUPPLIER			160	REET ADDRESS, CITY, STATE, ZIP CODE 11 ST LOUIS AVENUE ILUTH, MN 55802		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	· (X5) COMPLETION DATE
F 226	R61 used a walke R61's care plan da the potential to wa in search of her ov distract and reorie safe areas. The ca was at risk for inju diagnosis of deme her risk of wander On 9/3/16, a beha slammed R61's ha was in his room. F his call light to cal replied "whatever" 9/7/16, a progress indicated that on 9 another resident's redirected, the oth R61's hand. R61 s The physician was received to ice the days. On 10/26/16, at 1 was nothing to inc administrator were incident On 10/26/16, at 1 stated staff thoug abuse. The admin notes the next da didn't want it to be facility reported th in their minds.	ated 8/2/16, indicated R61 has under into other people's rooms wn. Staff were directed to nt the resident as needed to are plan also identified R 61 ry/abuse from others due to her entia, her cognitive deficits, and		226			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/:	27/2016
	PROVIDER OR SUPPLIE			1601	EET ADDRESS, CITY, STATE, ZIP CODE I ST LOUIS AVENUE LUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	of mistreatment a 9/16/16, in an atterm and the R76 fell from her abrasion to her fareported to the SA R76's Admission included Parkinson and low back pair 9/27/16, indicated cognition, and received mobility, transunit, dressing, toi MDS further indicassessment period R76's care plan also ideinjury/abuse from On 10/26/16, at 1 was found on the incident was not on 10/26/16, at 1 stated he believe immediately becauto be reported as injury. The admin have been report reach, thus the comperson reports to worker, director administrator. If	rgainst R76 to the SA. On empt to reach for her call light, wheelchair and received an ace. The incident was not A until 9/20/16 (time unknown). Record identified diagnoses that on's disease, vascular dementia, n. R76's quarterly MDS dated d R76 had moderately impaired quired extensive assistance with sfers, locomotion on and off the leting and personal hygiene. The cated R76 did not walk during the	F 2	226			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		SURVEY PLETED
		245227	B. WING	i		10/:	27/2016
	PROVIDER OR SUPPLIER	EHAB CTR		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	administrator. SW-reportable, the DON clinical group (morr during business hor record the time she the nurses docume does not think the se documented. SW-A administrator and the immediately, or "As reportable." SW-A sensure resident safinvestigation and m sometimes they do reportable until the often happens durin SW-A learns of the On 10/26/16, at 1:1 (DON) stated if the DON or the administrator stated he expects to reportable incident hours. The administrator stated he or SW-A determine if an everal administrator stated same way as he is exceed 24 hours. To report should be more than the doministrator stated incident. The administrator stated incident incid	A stated if an incident is N would be called. If not, the ning meeting) would discuss urs. SW-A stated she doesn't is notified of incidents, and int if the DON is notified. SW-A specific time of notification is A stated that the both the ne SA should be notified is soon as we determine it is estated the first step is to fety, and then begin the take reports. SW-A stated in't realize an incident is investigation starts, and this ng morning meetings or when	Fí	226			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245227	B. WING			10/2	7/2016
	PROVIDER OR SUPPLIER RE RESIDENCE & RI	EHAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226 F 242 SS=D	on abuse prohibitio	d they educate staff annually		226			
	schedules, and hea her interests, asse- interact with memb inside and outside	ne right to choose activities, alth care consistent with his or ssments, and plans of care; pers of the community both the facility; and make choices is or her life in the facility that he resident.			F 242-D Corrective Action: A. R15 will be offered showers planned days as he initially requested. If Resident refuse will be documented on the s	es it hower	
·	by: Based on observa review, the facility	NT is not met as evidenced ation, interview, and document failed to ensure bathing aces for 1 of 3 residents (R15) es.		-	worksheet with a reason for Additional offer for shower offered and if refused it will documented on the shower. The shower worksheet will audited the following day are followed to ensure the documentation is completed.	will be sheet. be nd	
	R15's Diagnosis R R15's diagnoses ir pulmonary disease diabetic neuropath The quarterly Minir 10/6/16, indicated had no behaviors of further indicated R with bed mobility, t personal hygiene. was occasionally ir indicated bathing of assessment period	eport dated 10/27/16, indicated included chronic obstructive (COPD), diabetes with y, and chronic kidney disease. The mum Data Set (MDS) dated R15 was cognitively intact, and or rejection of cares. The MDS 15 required staff assistance transfers, dressing and The MDS also indicated R15 incontinent of bladder. The MDS did not occur during the d. The annual MDS dated R15 required assistance with			Corrective Actions as it applies to o Residents: A. Facility will review all residents assure bathing needs and preferences are being met. Date of Completion: December 8, 20. Recurrence will be prevented by: A. Facility staff received educate bathing at the All Staff Meed completed the week of 11-2.	ther lents to 016 ation on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIER	EHAB CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE OULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) COMPLETION DATE	
F 242	bathing, and it was choose between a sponge bath. The care plan revis required the extens bathing (including the shower chair). The guide updated on Sthe bath list for bath Schedule updated was scheduled for Saturday on the aft. The facility's Showed Sheet Update form 10/18/16, indicated shower, R15 had on did refuse a shower the worksheet indicated shower becaus available, and they. During observation through 10/27/16, at appeared messy at over a month since R15 stated staff tell his shower. R15 fu shower a couple of shower day was Samore frequent shows shower on Tuesday shower on any day my hair every day in the state of the shower on any day my hair every day in the state of the shower on any day my hair every day in the shower on any day my hair every day in the shower on any day my hair every day in the shower on any day my hair every day in the shower of the shower on any day my hair every day in the shower of the sho	very important for R15 to tub bath, a shower, a bed or sive assistance of one staff for ransfer assistance to the nursing assistant (NA) care 1/23/16, directed staff to see in days. The Weekly Shower on 10/25/16, indicated R15 a shower on Tuesday and ternoon shift. The Day Worksheets/Body is from 9/3/16, through of 14 opportunities for a nly received 3 showers. R15 on 9/24/16, and on 10/15/16 ated staff was unable to do there was not enough staff were trying to train new staff. If rom 10/25/16, at 8:57 a.m. at 2:00 p.m. R15's hair	F 2	242	B. Facility will perform audits per week for 2 weeks, then audits for 4 weeks, then mo audits for 3 months. Findin be reported to the QAPI Co for review and follow up recommendations. The QA Committee will determine audits may be discontinued. Responsible Person: Director of Nur.	weekly nthly ags will mmittee .PI when the	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245227	B. WING			10/2	7/2016
	ROVIDER OR SUPPLIER	EHAB CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	unable to get the a were only two nurs unit, with a float NAON (LPN)-A stated R15 because he stayed day. R15 refused it R15 was schedule Saturday in the afterind documentation On 10/27/16, at 2:4 worked afternoons she had never had (DON) stated he was scheduled a bath twice week. If bath, the DON worecorded, with the refused. The DON to be offered a bat why a resident refu DON would expecimedical record. The sheets were derived.	A)-C stated the staff was fternoon baths done as there ing assistants (NA) on R15's A between two units. p.m. licensed practical nurse 5 refused the shower at times I up late and would sleep all if he was sleepy. LPN-A verified I de for a shower on Tuesday and ernoon. LPN-A was unable to not R15's refusals. 40 p.m. NA-M stated she on R15's unit. NA-M stated R15 refuse a shower. 20 p.m. the director of nursing rould expect a resident who eath twice a week, to receive a a resident did not receive a lud expect the refusal to be reason why the resident would then expect the resident he he next day, and/or find out used a bath and reassess. The trefusals be documented in the next day in the care plan. The care the information was carried	F2	242			
F 282 SS=D	choices. 483.20(k)(3)(ii) SE PERSONS/PER C	able to provide a policy on RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility	F	282			
	,						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245227	B. WING		10/2	27/2016	
	PROVIDER OR SUPPLIER RE RESIDENCE & R			STREET ADDRESS, CITY, STATE, ZIP CO 1601 ST LOUIS AVENUE DULUTH, MN 55802	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	accordance with e care. This REQUIREME by: Based on observareview, the facility preferences as dir residents (R15) readdition, the facilit for toilet use was f (R128) reviewed for Findings include: R15's Diagnosis FR15's diagnoses in pulmonary diseased diabetic neuropath. The quarterly Mini 10/6/16, indicated had no behaviors further indicated F with bed mobility, personal hygiene. was occasionally indicated bathing assessment perio 7/7/16, indicated F bathing, and it was choose between a sponge bath. The care plan revirequired the exterior assessment perior assessment perior for the care plan revirequired the exterior for the care plan revirequired for the care plan revirequired the exterior for the care plan revired for the care plan revir	by qualified persons in ach resident's written plan of ach resident's written plan of ach resident's written plan of action, interview and document failed to accommodate bathing ected by the care plan for 1 of 3 viewed for bathing choices. In y failed to ensure the care plan ollowed for 1 of 3 residents	F 282	F 282-D Corrective Action: A. R15 will be offered sl Plan of Care indicates qualified staff to perfe If Resident refuses, it documented on the sh worksheet with a reas Additional offer for s offered and if refused documented on the sh B. R128 will be toileted per Plan of Care. Staf regarding following the Care and communicates staff/departments to e toileting schedule is recare. Corrective Actions as it applies Residents: A. The Care Plan policy reviewed and revised B. The Bathing Care pol reviewed and revised C. The Call Light policy and revised. D. All Facility staff men educated on the Care Care and Call Light F All Staff meetings co week of 11-28-16.	s with the form the task. will be form for refusal. hower will it will be forwer sheet. as indicated ff education the Plan of the per Plan of the per Plan of the per Plan of the stoother was reviewed to the per Plan, Bathing Policy at the		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245227	B, WING			10/2	27/2016
	PROVIDER OR SUPPLIER	EHAB CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	shower chair). The guide updated on Sthe bath list for bat Schedule updated was scheduled for Saturday on the af The facility's Show Sheet Update form 10/18/16, indicated shower, R15 had odid refuse a shower the worksheet indicated shower because available, and they During observation through 10/27/16, appeared messy at On 10/25/16, at 8:3 over a month since R15 stated staff te his shower. R15 fushower a couple of shower day was Smore frequent shot shower on Tuesdate shower on Tuesdate shower on any day my hair every day On 10/27/16, at 2:3 administrator (TMA) unable to get the affect were only two nursunit, with a float Na On 10/27/16, 2:30	e nursing assistant (NA) care 6/23/16, directed staff to see h days. The Weekly Shower on 10/25/16, indicated R15 a shower on Tuesday and ternoon shift. The Pay Worksheets/Body as from 9/3/16, through dof 14 opportunities for a only received 3 showers. R15 or on 9/24/16, and on 10/15/16 cated staff was unable to do se there was not enough staff were trying to train new staff. The from 10/25/16, at 8:57 a.m. at 2:00 p.m. R15's hair	F	282	Pate of Completion: December 8, 20 Recurrence will be prevented by: A. All Facility staff members weducated on the Care Plan, Eare and Call Light Policy a All Staff meetings completed week of 11-28-16. B. Facility will perform audits a per week for 2 weeks, then we audits for 4 weeks, then more audits for 3 months. Finding be reported to the QAPI Confor review and follow up recommendations. The QAI Committee will determine we audits may be discontinued. Responsible Person: Director of Nurse.	ere Bathing t the d the 4x's veekly othly gs will nmittee	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE	PLETED
		245227	B. WING			10/2	7/2016
	PROVIDER OR SUPPLIER			16	TREET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	day. R15 refused in R15 was schedule Saturday in the affind documentation On 10/27/16, at 2: worked afternoons she had never had On 10/26/16, at 2: (DON) verified the	age 19 d up late and would sleep all if he was sleepy. LPN-A verified ed for a shower on Tuesday and ternoon. LPN-A was unable to n of R15's refusals. 40 p.m. NA-M stated she is on R15's unit. NA-M stated d R15 refuse a shower. 40 p.m. the director of nursing o care plan should be followed. In the care plan was requested	F	282			
	identified diagnos urinary incontinent R128's admission dated 10/7/16, incimpairment of cog decision-making. with transfers with assist of 2 staff for indicated he was frequently incontinuated to the communication in th	n Record printed 10/26/16, es that included dementia, ice, and diverticulosis. n Minimum Data Set (MDS) dicated R128 had moderate gnitive skills for daily R128 required total assistance in two staff assist and extensive or toilet use. R128's MDS always incontinent of urine and ment of bowel. dated 10/7/16, directed staff to set R128's needs, as he has a inpairment. The care plan further ites frequently incontinent of					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE OULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	bowel and bladder and change R128 for incontinence, a The care plan furth stand-aid with 2 strequired extensive. The Nursing Home 10/25/16, directed hours with assist owith the stand-aid R128's Bowel and indicated R128 wa and required exter The Bowel and Blawas confused and On 10/26/16, at 7: observations of Rwas brought from unit common area a.m. R128 was brought from unit common area a.m. At 9:11 a.therapy aide (COT the common area noted, stated she minutes earlier an at 6 a.m. and start body cares. The Cworked with R128 continued to work incontinence odor	and directed staff to check every 2 hours and as required and change clothing as needed. The indicated R128 required the aff assist for transfers, and assist of 2 staff for toilet use. Assignment Sheet updated staff to toilet R128 every two f 2 staff and to transfer R128 lift. Bladder Program Screener, and assist and to transfer R128 lift. Bladder Program Screener, and assistance for toilet use. adder screener indicated R128 needed prompting.	F	282			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245227	B. WING		10	/27/2016
	ROVIDER OR SUPPLIER	EHAB CTR		STREET ADDRESS, CITY, STATE, ZIP C 1601 ST LOUIS AVENUE DULUTH, MN 55802	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 282	therapist took R12i wheelchair. At 10:1 R128's wheelchair the TV and left the R128 had returned At 10:12 a.m. nurs R128 to his bathrod 2 1/2 hours since in observations and a minutes since reside was gotten up for the incontinent brief wand smelled strong movement (BM) in into the garbage. No soiled with urine an incontinent brief hat therapy the first time R128 before thera	rapy. At 10:07 a.m. the physical 8 down the hall in his 0 a.m. physical therapist set in the common area in front of unit. Staff were not informed	F2	282		
F 315 SS=D	(DON) verified the 483.25(d) NO CAT	40 p.m. the director of nursing care plan should be followed. THETER, PREVENT UTI, DER	F:	315		
	assessment, the faresident who enter indwelling cathete resident's clinical catheterization was who is incontinent treatment and sen	dent's comprehensive acility must ensure that a rs the facility without an r is not catheterized unless the condition demonstrates that as necessary; and a resident of bladder receives appropriate vices to prevent urinary tract estore as much normal bladder				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		SURVEY PLETED
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIER	EHAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	Continued From pa	_	F:	315	F315-D		
	by: Based on observareview the facility for assistance was proceed (R128) reviewed for Findings include: R128's Admission identified diagnose urinary incontinence. R128's admission Idated 10/7/16, indicimpairment of cogred decision-making. Finding with transfers with assist of 2 staff for indicated he was a frequently incontine. R128's care plan dianticipate and mean communication implicated R128 was bowel and bladder and change R128 for incontinence, a The care plan furth stand-aid with 2 starequired extensive. The Nursing Home 10/25/16, directed.	Record printed 10/26/16, s that included dementia, e, and diverticulosis. Minimum Data Set (MDS) cated R128 had moderate nitive skills for daily R128 required total assistance two staff assist and extensive toilet use. R128's MDS lways incontinent of urine and			Corrective Action: A. R128 will be toileted as indeper Plan of Care. B. Staff education regarding for the Plan of Care and communication between staff/departments to ensure toileting schedule is met per Care. Corrective Actions as it applies to othe Residents: A. Facility will follow toileting care for all residents. B. Staff education regarding for the Plan of Care and communication between staff/departments to ensure toileting schedule is met per Care. Date of Completion: December 8, 20. Recurrence will be prevented by: A. All Facility staff members we educated on following the purchase and CNA care sheets a Staff Meetings completed the of 11-28-16.	Plan of plan of plan of plan of the All	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIER RE RESIDENCE & RI	EHAB CTR		16	REET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	with the stand-aid I R128's Bowel and indicated R128 was and required exten The Bowel and Bla was confused and On 10/26/16, at 7:4 observations of R1 was brought from t unit common area a.m. R128 was brobreakfast. At 8:30 the dining room to front of the TV. At physical therapy. Continued through session. At 9:11 a. therapy aide (COT the common area noted, stated she minutes earlier and at 6 a.m. and starte body cares. The C worked with R128 continued to work incontinence odor COTA stated staff him up prior to the therapist took R12 wheelchair. At 10: R128's wheelchair the TV and left the R128 had returned At 10:12 a.m. nurs R128 to his bathro	Bladder Program Screener, so always incontinent of bladder sive assistance for toilet use. dder screener indicated R128 needed prompting. If a.m. continuous 28 were initiated when R128 herapy in a wheelchair, to the to watch television. At 7:56 aught to the dining room for a.m. R128 was brought from the common area and set in 8:50 a.m. R128 was brought to continuous observations R128's physical therapy m. certified occupational A), who had brought R128 to be the unit before breakfast, as and worked with R128 for 70 distated she gets at the facility ed working with him on upper OTA verified she had not on toileting. At 9:52 a.m. R128 in physical therapy and a slight was detected. At 10:06 a.m. toileted R128 when they got rapy. At 10:07 a.m. the physical 8 down the hall in his 10 a.m. physical therapist set in the common area in front of unit. Staff were not informed	F3	315	B. Facility will perform complaudits 4x's per week for 2 we then weekly audits for 4 weethen monthly audits for 3 me Findings will be reported to QAPI Committee for review follow up recommendations QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nur	veeks, eks, onths. the v and . The mine	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245227	B. WING _		10/2	7/2016
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	minutes since reside was gotten up for the incontinent brief was and smelled strong movement (BM) in into the garbage. As soiled with urine ar incontinent brief has therapy the first time R128 before therapy NA-B stated she use hours. On 10/26/16, at 2:4 (DON) stated R126	approximately 3 hours and 40 dent was changed when he herapy the first time. R128's as removed in the bathroom gly of urine and also had bowel the brief. NA-B threw the brief IA-B verified the brief was and BM. NA-B verified R128's and been changed before he, and she had not toileted by took him to therapy again. Sually checks him every 2	F 31	15		
F 353 SS=F	be followed. A policy and proce for toilet use was r 483.30(a) SUFFIC PER CARE PLAN: The facility must h provide nursing an maintain the highe and psychosocial determined by resindividual plans of The facility must p numbers of each opersonnel on a 24	IENT 24-HR NURSING STAFF S ave sufficient nursing staff to a related services to attain or est practicable physical, mental, well-being of each resident, as ident assessments and	F 3	53		
	care plans: Except when waiv	ed under paragraph (c) of this				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	riple construction		(X3) DATE SURVEY COMPLETED	
		245227	B. WING_		10/:	27/2016	
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 353	Except when waiv section, the facility nurse to serve as duty. This REQUIREME by: Based on observer review, the facility nursing staff was who resided in the Findings include: See F242 Choices provide adequate bathing preference reviewed for choices of the facility failed to provide a colleting for 1 of 3 urinary incontinents. RESIDENT CONCADEQUATE STAFF R155's quarterly Navigation of the facility dependent transferring and to a.m. R155 stated	ed under paragraph (c) of this must designate a licensed a charge nurse on each tour of entry is not met as evidenced ation, interview, and document failed to ensure adequate provided for all 108 residents facility. Solve as the facility failed to staffing to accommodate es for 1 of 3 residents (R15) ees. Incontinence - as the facility onsistent staff assistance with residents (R128) observed for ce. CERNS WITH THE LACK OF FING: Minimum Data Set (MDS) dated R155 was cognitively intact, was on staff for assistance with bileting. On 10/25/16, at 9:50 that she had waited for over an	F 35	F353-F Corrective Action: A. R15 will be offered shochoice with Plan of Care Resident choice. R128 toileted as Plan of Care R155 has discharged. C time monitored and anstimely. R29 Nursing ac be audited to ensure the does not wait an excess of time for oxygen place bedtime and staff educategarding call light response/intervention. B. Staffing levels for RN' TMA's, and CNA's, we reviewed daily by the I Nursing and/or Designer C. Call Light expectations reviewed with all facility Call Light audit form designed. D. Bathing preferences we with all residents to me needs. E. Water Pass Policy revisions reviewed.	re reflecting will be e indicates. Call light swered ctivity will at resident sive amount cement at ation s, LPN's, rill be Director of ee. s are ity staff. developed. ere reviewed eet their		
	R155 stated she s	ember to answer her call light. started to scream out, and then ally come. In addition, R155					

	OF DEFICIENCIES OF CORRECTION					
		245227	B. WING		10/2	27/2016
	PROVIDER OR SUPPLIER PRE RESIDENCE & RI	EHAB CTR		STREET ADDRESS, CITY, STATE, ZIP 1601 ST LOUIS AVENUE DULUTH, MN 55802	CODE	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 353	stated the staff see assisted her with caright. R29's quarterly MD R29 was cognitively therapy. On 10/27, there was not enounight shift and at tir on who covered bo stated the evening on around 12:30 a. to place his oxygen the nurse arrived a later) and placed his he didn't want to fabeen placed as he oxygen at night whitmes the nursing a turn the call light of back, and then the he didn't like when before they address FAMILY CONCERI ADEQUATE STAF When interviewed family member (FM dependent on staff 10/25/16, during the visiting his wife, she bowel and a nursin needed to get som stated the nursing anyone to help so before the nursing her up. FM-A state	emed to be rushed when they ares and that just didn't feel 2S dated 9/27/16, indicated y intact and used oxygen (16, at 10:22 a.m. R29 stated ugh nursing assistants on the mes there was only one nurse the floors at the facility. R29 prior he had put his call light m. as R29 required assistance on for the night. R29 stated t2:00 a.m. (an hour and a half is oxygen on him. R29 stated at assistants would come in and fe and say they would be right y didn't come back. R29 stated the staff turned the call light off sed his needs. NS WITH LACK OF	F3	Corrective Actions as it appressidents: A. Facility has review levels to ensure far sufficient staffing resident needs and This is done throus evaluation of reside acuity levels by Donursing and/or Description Date of Completion: December A. All Facility staff in educated on the case expectation, water bathing compliance incontinence cares Meetings completed 11-28-16. B. Facility will perform per week for 2 were audits for 4 weeks audits for 3 month be reported to the for review and followed recommendations. Committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsible Person: Administration of the committee will deaudits may be disconsibled.	ved staffing cility has levels to meet preferences. gh daily lent census and irector of ssignee. mber 8, 2016 ed by: nembers were ll light pass policy, le sheets, and le at the All Staff ed the week of left the week of left the weekly, then monthly so and left the weekly, then monthly so are provided left the weekly, then monthly so are provided left the left the weekly with the left the left the when the left the when the left the left the weekly with the left the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED		
		245227	B. WING		10/	27/2016	
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 353	nice if I didn't have time." FM-A stated his heart that she needed or deserve came the facility to STAFF CONCERN On 10/25/16, at 10 (NA)-A, who also vaide (TMA), stated surveyors were at be fully staffed. Nassistants had a hoileted and reposition when she had wor the nursing assistant however, then she resident's medicate On 10/26/16, at 7: had been short staffed. On 10/26/16, at 7: dressing change of (LPN)-B stated, she facility because the residents didn'met like being offer when they should felt that was why to developed pressurseptic.	ng. FM-A stated, "It would be to worry about her all the he felt frustrated and it broke wasn't receiving the care she ed. FM-A stated he routinely visit his wife twice a day. NS: 2:58 a.m. nursing assistant worked as a trained medication he appreciated when the the facility as they seemed to A-A stated the nursing ard time getting residents tioned on time. NA-A stated ked as a TMA, she tried to help ants out when she could, was late on administering the	F 353				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245227	B. WING		trainers are the same of the s	10/2	27/2016
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR				1	STREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	during survey time schedule more staff On 10/26/16, at 10: was hard. NA-B wa locked dementia ur stated she called for she needed to trans. On 10/26/16, at 11: needed to be more NA-G stated she was not able to stated residents did or changed when the stated she didn't ge NA-G stated the re up for themselves in needed, because the staff when they needed, because they no longer had assistants also had besides completing. On 10/2716, at 8:23 was routinely short was able to complestayed beyond her when she charted. On 10/27/16, at 9:23 was asked to stay ever shift she work mandated to stay ever shift she work mandated to stay of scheduling period.	ed very hard. NA-F confirmed the facility seemed to f. 12 a.m. NA-B stated staffing is the only person on the nit with eight residents. NA-B or help from another unit when is fer a resident. 34 a.m. NA-G stated things organized at the facility. Orked full time and every two as mandated to stay and work NA-G stated most of the time of get her work done. NA-G is not get repositioned on time ney should. In addition, NA-G is ther charting completed. Sidents that could not speak may not get the care they ney were unable to remind the eded something. NA-G stated a bath aide, so the nursing it to do so many baths a day	F	353			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/2	7/2016
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR				1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE OULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	mandated to stay for one weekend five shift were mandated NA-H stated there to get the work corgot missed or delateeth, getting resid time, and checking were incontinent. her until noon to costated normally shresidents, howeve required two staff assistants just tried On 10/27/16, at 9: been mandated to orientation. NA-I senough staff to castated there were 36 residents on thresidents who wer stated she had see because they had and should have hwith the transfer. residents who wer toileted timely due available. On 10/27/16, at 10 as a TMA, stated was always pulled assistants. NA-J TMA, she would hwas assigned and medications, proversidents' blood si	or the same shift. NA-H stated staff members from the day ed to stay for the evening shift. was not enough staff members impleted. NA-H stated things yed like brushing residents lents turned or repositioned on and changing residents who NA-H stated sometimes it took omplete morning cares. NA-H e was assigned about 10 r since most of the residents members, the nursing d to work as a team. 31 a.m. NA-I stated she had stay over on her third day of stated she felt there were not re for the residents. NA-I only two nursing assistants for e day shift, with only five of the e fairly independent. NA-I en staff hurt themselves lifted residents by themselves and two staff members assisting NA-I stated she was aware of the not turned, repositioned, or to not having enough staff 0:24 a.m. NA-J, who also works when she worked as a TMA she away to assist the nursing stated when she worked as a tave 34 residents which she ave 34 residents which she ave 34 residents monitoring ugars, and administering the times when the same times the same times when the same times when the same times when the same times the same times when the same times the same times the same times when the same times to the same times the same t		353			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i .		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/2	27/2016
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR				1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	one nurse was ass medications on. N not get done. NA-residents who were themselves and why them with transfers wheelchairs in the until 1:00 p.m. with changed. NA-J statheir baths, especially was always stated two weeks a assistant for 24 resin, and she worked other staff member medications. On 10/27/16, at 10 residents who camput on their call light they needed becauprovide the care. On 10/27/16, at 1: with director of nurhuman resource distaffing was one of had. DON stated the council meetings if concerns with time answered. DON sup as an area of cattended the reside facility had not con response time audicatively advertising	igned 51 residents to pass A-J stated resident cares do J stated she was aware of e not able to speak for no required two staff to assist s, had sat up in their common area from 7:00 a.m. out being repositioned or ated residents are not getting ally on the second floor units ally two nursing assistants 6 residents. NA-J stated the running short of staff. NA-J ago they only had one nursing sidents, so she called someone as a nursing assistant and the rook on NA-J's duties to pass an unity and the rook on NA-H stated the not speak up for themselves or the them to the term of th		353			

245227 B. WING 10/27	7/2016
1 1 <i>V/21</i>	
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353 Continued From page 31 staff. HRD confirmed the facility currently had five open licensed staff (RN/LPN) positions, and at least ten open nursing assistant positions. DON stated the staff were good about filling in the open shifts, but everyone needed a break and nobody liked to be mandated to stay. Scheduler confirmed in a two week period the facility was on an average, mandating about 10 shifts (this included licensed staff and nursing assistants). The scheduler confirmed the staffing needs for the facility were: - Day and evening shift = 4 licensed staff (RN/LPN) and 13 nursing assistants - Night shift = 3 licensed staff (RN/LPN) and nine nursing assistants On review of the Nursing Schedules from October 2, 2016, through November 12, 2016, the schedules indicated the following open shifts: - Licensed staff (RN/LPN) = 103 shifts - Nursing assistants = 154 shifts On review of the facility's Direct Staff Working Hours postings for the last 30 days (9/25/16-10/24/16) the following was reflected: Day shift (6:00 a.m 2:00 p.m.): * licensed staff (RN/LPN) = short 20 out of 30 days; averaged one licensed staff short per day shift Evening shift (2 p.m 10:00 p.m.): * licensed staff (RN/LPN) = short 20/30 days; averaged one licensed staff from licensed staff short per evening	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245227	B. WING	i		10/2	7/2016
	PROVIDER OR SUPPLIER RE RESIDENCE & RE	EHAB CTR		16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353 F 431 SS=E	from 1-5 staff short short per evening so Night shift (10:00 point in the licensed staff (RN) averaged one licenth in the licensed staff short short per night shift A policy on staffing provided. 483.60(b), (d), (e) I LABEL/STORE DFO The facility must end a licensed pharmac of records of receip controlled drugs in accurate reconciliar records are in order controlled drugs is reconciled. Drugs and biologic labeled in accordant professional principal appropriate accessinstructions, and the applicable. In accordance with facility must store a locked compartment in the locked compartment in the short per evening staff short	s = short 30/30 days; ranging with an average of 3 staff hift m 6:00 a.m.): //LPN) = short 18/30 days; sed staff short per shift s = short 30/30 days: ranged with a an average of 3 staff was requested and none DRUG RECORDS, suGS & BIOLOGICALS Imploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be not with currently accepted oles, and include the cory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to		431	F 431- E Corrective Action: A. Insulin for residents R10, R1 R97, R152, R13, R155, R15 R44, R14, R1, R100, R46, R R200, and R18 will be separ appropriate barrier to preven contamination for each device have proper labels with direct b. Multi-use Insulin pens have labeled appropriately by the pharmacy. C. Internal and External medica are now stored separately on medication carts, treatment of and in the medication rooms medication refrigerators.	R146, R30, rated by at cross-ce and ctions. been ations a the carts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING	;		10/	07/001 <i>C</i>
	PROVIDER OR SUPPLIER DRE RESIDENCE & R		<u>.</u>	160	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE ULUTH, MN 55802	[10/	27/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	permanently affixed controlled drugs list Comprehensive Drugs Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districted quantity stored is in the readily detected. This REQUIREMED by: Based on observative, the facility flad labels with direction that the store of th	rovide separately locked, d compartments for storage of sted in Schedule II of the rug Abuse Prevention and a and other drugs subject to in the facility uses single unit libution systems in which the ninimal and a missing dose can libution. NT is not met as evidenced tion, interview, and document ailed to ensure insulin pensiotions for 16 of 16 (R10, R13, R155, R15, R146, R44, 6, R30, R200, R18) residents ens. In addition, the facility tanyl patches were properly int diversion on 5 of 5 units. 11:49 a.m. through 12:29 a.m. in each unit contained insuling 6 residents that were not cons for use. The insulin pension or sof sundant in the sident names. Cian orders dated 10/5/15, orders for Lantus and Novolog intus and Novolog insulin pension.	F	431	Corrective Actions as it applies to of Residents: A. The Medication Storage Pobeen reviewed and revised. B. The Labeling of Medication procedure has been educate nursing staff. Date of Completion: December 8, 26 Recurrence will be prevented by: A. Facility staff members were educated on the revised Medications procedure at the Staff Meetings completed the of 11-28-16. B. Facility will perform audits per week for 2 weeks, then we audits for 4 weeks, then mod 3 months. Findings will be reported to the QAPI Comm for review and follow up recommendations. The QAC Committee will determine wardits may be discontinued. Responsible Person- DON	licy has Is Is Is It Is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245227	B. WING	i		10/2	27/2016	
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 431	R97's signed phys indicated R97 had insulin. R97 had a medication cart. R152's signed phys indicated R152 ha Novolog insulin. R in the medication cart. R13's signed phys indicated R13 had insulin. R13 had insulin. R13 had insulin. R155's signed phys indicated R155 had the medication cart. R15's signed phys indicated R15 had Lantus. R155 had the medication cart. R16's signed phys indicated R15 had Liraglutide Insulin. medication cart. R146's signed phys indicated R146 had Novolog insulin. Rpens in the medication. R44's signed phys indicated R44 had Lantus insulin. R4 pens in the medication. R4	ician orders dated 10/24/16, orders for Lantus and Novolog Novolog insulin pen in the sician orders dated 10/24/16, d orders for Detemir and 152 had Novolog insulin pensoart. ician orders dated 9/7/16, orders for Lantus and Novolog lovolog and Lantus pens in the sician orders dated 10/17/16, d orders for Humalog and Humalog and Lantus pens in the sician orders dated 9/27/16, orders for Lantus, Aspart and R15 had a Victoza pen in the sician orders dated 9/10/16, d orders for Lantus and Novolog ation cart.	F	431				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		245227	B. WING		10/	27/2016
	PROVIDER OR SUPPLIER RE RESIDENCE & R	EHAB CTR	16	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa	age 35	F 431			
	indicated R1 had o	ian orders dated 9/7/16, rders for Lantus and Novolog ntus and Novolog insulin pens art.				
	indicated R100 had	sician orders dated 9/15/16, d orders for Lantus and Novolin a Lantus pen in the medication				
	indicated R46 had	cian orders dated 10/17/16, orders for Lantus and Novolog to Lantus insulin pens in the				
	indicated R30 had	cian orders dated 10/12/16, orders for Lantus and Novolog antus and Novolog pens in the				
	indicated R200 had	sician orders dated 10/12/16, d orders for Lantus insulin. s insulin pen in the medication		·		
	indicated R30 had	cian orders dated 9/19/16, orders for Humalog and 3 had Humalog and Lantus in t.				
	(RN)-C verified the directions for use of RN-C stated the in- pharmacy in bags or box. RN-C state	:29 p.m. registered nurse are were no labels with on any of the insulin pens. sulin pens were sent from the or boxes with labels on the bag d the bag or box had been the pen was removed for the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED		
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	On 10/26/16, at 1 pharmacist stated label with direction container it is stored on 10/27/16, at 3 (DON) verified insproper labels with package or pen. On 10/26/16, at 1 patches (a narcot were disposed of container used for Sharps containers medication carts. sharps containers residents, visitors sharps containers unattended in the On 10/26/16, at 1 pharmacist stated followed for destrict fentanyl patches signed for the seven pharmacist verifier on the disposed of On 10/27/16, at 1 On 10/27/16, at 1	page 36 306 p.m. the consultant I the insulin pens should have a ns for use on the pen or on the ed in. 342 p.m. the director of nursing sulin pens should have the directions for use on each 2:38 p.m. RN-C stated fentanyl ic pain medicated skin patch) in the sharps containers (a r the storage of used needles). It is were secured to the The flip-top openings to the secure of the swere not secured. All and staff had access to the secure of the swere left hallways. 3:06 p.m. the consultant of the facility policy should be should be folded together and over system. The consultant and the fentanyl patches should of in the sharps containers. 3:19 a.m. licensed practical	,	431	DEFICIENCY)		
	cut up and dispossharps container cart in the hallway counter in the rocopen. LPN-A ver room to read the	ated used fentanyl patches were sed of in the sharps container. A was observed on the medication y, unsecured and one on the om behind the desk with the door ified findings. All staff access the communication board and erator. LPN-A stated the sharps					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/2	27/2016
	PROVIDER OR SUPPLIER RE RESIDENCE & RE	EHAB CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	they were brought of area located outside outside agency/disp containers up from On 10/27/16, at 10: was on the counter on the Beachwalk upon the Beachwalk upon 10/27/16, at 10: sharps containers at the desk. RN-A also the sharps contained disposed of in the second of the sharps contained disposed of in the stated they were to in the sewer system were flushing them into the sharps combiohazard storage is containers were brown to be the disposal commetal shed that was attached to a cable the roof of the sheet stated the nurses a aides (TMA) knew and the contents of maintenance would administrator came storage bin and who for diversion, he staright away. The key was removed and its containers were displayed and its containers were storage by the disposal commetal shed that was and the contents of maintenance would administrator came storage by the disposal containers were storage by the disposal containers were brown and the contents of maintenance would administrator came storage by the disposal containers were brown and the contents of maintenance would administrator came storage by the disposal containers were brown and the contents of maintenance would administrator came storage by the disposal contents of the sheet contents of the	kept in the back room until down to the locked storage e the facility. LPN-A stated an losal picks the sharps there. 41 a.m. a full sharps container in the room behind the desk unit. 53 a.m. RN-A verified the should not be in the room by overified staff had access to ers, and fentanyl patches are sharps containers. 4 p.m. RN-A stated she narmacist and the policy and be flushing fentanyl patches in RN-A verified some nurses and some were putting them tainers. RN-A identified the bin, where the sharps ought for storage until pick up in pany. The storage bin was a solocked, and the key was and hanging on a cable under l, just above the lock. RN-A and the trained medication about the location of the key the shed, and also stated also know about it. The coutside, to the biohazard en asked about the potential ated the key would be removed to the biohazard storage bin orought to a locked drawer on is to the drawer were to be	F	431			

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245227	B. WING	-		10/2	7/2016
	RE RESIDENCE & RI	EHAB CTR		10	TREET ADDRESS, CITY, STATE, ZIP CODE 501 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From page 38 On 10/27/16 at 2:19 p.m. TMA-B stated fentanyl patches were disposed of in the sharps container.		F4	431			
	(DON) stated the for destroyed by flushing of in the sharps consharps were availang residents. The DOI	29 p.m. the director of nursing entanyl patches should be ng and should not be disposed ntainers. The DON verified the ble to all staff, visitors, and N also verified the key should storage shed for the					
	Storage of Medical that have missing,	y policy and procedure for tions directed drug containers incomplete, improper, or all be returned to the pharmacy before storing.					
F 441 SS=F	Discarding and De nursing to destruct manner that would longer usable or av illegally diverted. 483.65 INFECTION	y policy and procedure for stroying Medications directed controlled substances in a render it "non-retrievable," no vailable and could not be	F	441			
	Infection Control P safe, sanitary and	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection.					
	Program under wh	stablish an Infection Control					

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	J		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245227	B. WING	·		10/	27/2016
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	EHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFICIENCY)		8E	(X5) COMPLETION DATE
F 441	should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tra (3) The facility must	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections. ad of Infection ion Control Program esident needs isolation to of infection, the facility must ase or infected skin lesions with residents or their food, if ansmit the disease. I require staff to wash their rect resident contact for which licated by accepted	F	141	F 441- F Corrective Action: A. Resident Infections and Em Illness are now being logge trending purposes. Corrective Action as it applies to oth Residents: A. The Infection Control Surve Policy has been revised. B. An Employee Illness Log h implemented. The Residen Infection Log was reviewed. C. Handwashing training and competency provided to all staff. Date of Completion: December 8, 2	d for her eillance as been t d. facility	
	transport linens so a infection. This REQUIREMEN by: Based on observat review, the facility fa an ongoing, compresurveillance prograit trending of infection effect all 108 reside in addition, the facil injectable pens were prevent cross contains.	andle, store, process and as to prevent the spread of of the spread of t			A. Facility Staff received educe hand washing, the Infection Control Surveillance Policy Resident Infection Log and Employee Illness log at the Staff meetings completed the of 11-28-16. B. Facility will perform audits per week for 2 weeks, then audits for 4 weeks, then must a months. Findings will be reported to the QAPI Common for review and follow up recommendations. The QAPI Committee will determine audits may be discontinued	y, the the All ne week 4x's weekly onthly x nittee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/	27/2016
	PROVIDER OR SUPPLIER PRE RESIDENCE & F			1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	addition, the facilit hand hygiene pracassisting 1 of 3 restoilet use. Findings include: On 10/27/16, at 2: (DON) was interviwas responsible for The DON verified identifying and tracular DON also stated to program in place to infection/ infection antibiotic initiation, the infection contraction was used.	age 40 ation cart on all 5 units. In y failed to ensure appropriate ctices were maintained while sidents (R128) reviewed for 10 p.m. the director of nursing ewed and confirmed that he or the infection control problem. the facility lacked a system for cking resident infections. The here is not a surveillance o include monitoring of any identification, culture prior to and tracking. The DON stated of program was in it's infancy. ection control logs to review. hable to provide a policy on revention and surveillance.	F	141			
	medication carts of pens for a total of together in the sar cart, without separ verified that there	11:49 a.m. through 12:29 a.m. on each unit contained insulin 16 residents that were stored me containers/bin or area of the ration from each other. RN-C is a risk of cross-contamination hogens by storing the insulin				;	

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED		
		245227	B. WING	i		10/2	27/2016
	PROVIDER OR SUPPLIER	EHAB CTR		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From part R10's physician orders for Lantus and Novolog medication cart/bin R117's signed physicantus and Humal and Novolog insulicart/bin. R97's signed physicated R97 had a medication cart/bin R152's signed physicated R152 had Novolog insulin. Rin the medication cart/bir R13's signed physindicated R13 had insulin. R13 had N medication cart/bir R155's signed physicated R13 had insulin. R13 had N medication cart/bir R155's signed physicated R13 had insulin. R13 had N medication cart/bir R155's signed physicated R155's signed P155's signed	ders dated 10/17/16, indicated Lantus insulin. R10 had g insulin pens in the land. sician orders dated 10/17/16, og insulin. R117 had Lantus in pens in the medication dician orders dated 10/24/16, orders for Lantus and Novolog Novolog insulin pen in the land. sician orders dated 10/24/16, dorders for Detemir and 152 had Novolog insulin pens cart/bin. dician orders dated 9/7/16, orders for Lantus and Novolog ovolog and Lantus pens in the land.	F	441			
	Lantus. R155 had the medication car R15's signed phys indicated R15 had	ician orders dated 9/27/16, orders for Lantus, Aspart and R15 had a Victoza pen in the				-	
	R146's signed phy indicated R146 ha	rsician orders dated 9/10/16, d orders for Lantus and 146 had Lantus and Novolog	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245227	B. WING			10/2	27/2016
,	PROVIDER OR SUPPLIER RE RESIDENCE & R			1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	indicated R44 had Lantus insulin. R4 pens in the medicated R14 had Lantus at medication cart/bin. R1's signed physic indicated R1 had consulin. R1 had Lantus at the medication of R100's signed physicated R100 had cart/bin. R46's signed physicated R46 had insulin. R46 had the medication cart/bin. R30's signed physicated R30 had insulin. R30 had Locart/bin. R200's signed physicated R200 had a Lantucart/bin. R18's signed physicated R30 had a Lantucart/bin.	ation cart/bin. sician orders dated 9/7/16, l orders for Humalog and 4 had Humalog and Lantus ation cart/bin. Ind Novolog insulin pens in the Ind. Indian orders dated 9/7/16, Index and Novolog insulin pens Indian orders dated 9/15/16, Indian orders dated 9/15/16, Indian orders dated 9/15/16, Indian orders dated 10/17/16, Indian orders dated 10/17/16, Indian orders dated 10/17/16, Indian orders dated 10/17/16, Indian orders dated 10/12/16, Indian orders dated 9/19/16, Indian orders dated 9/19/1		141			
	Lantus insulin. R1	8 had Humalog and Lantus e medication cart/bin.					

PRINTED: 11/09/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	AND DI AN OF CORPECTION		TIPLE CONSTRUCTION ING		COMPLETED	
		245227	B. WING		10	/27/2016
	PROVIDER OR SUPPLIER PRE RESIDENCE & RI	EHAB CTR		STREET ADDRESS, CITY, STATE, ZII 1601 ST LOUIS AVENUE DULUTH, MN 55802	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 43	F4	141		
	(DON) directed the separate plastic ba anti-microbial wipe: On 10/26/16, at 12 this is a wide sprea pen with the appropulation DON instructed the the insulin pens with	59 a.m. the director of nursing nurses to put the insulin in ggies after cleaning them with a for blood-borne pathogens. 607 p.m. the DON stated that d problem and wiped off each briate antimicrobial wipes. The enurses on each unit to clean h the appropriate wipes and ely in a plastic baggie for each				
	(NA)-B assisted R1 assisted by NA-M tusing the stand-aid gloves on. NA-B puremoved R128's in soiled with urine ar the brief in the gark stand-aid lift from t gloved hands. NA-new gloves. NA-B R128, brought in the stand aid lift straps buttocks with disportence of gloves ar R128 was brought rest, the recliner's was put on, and a R128. NA-B gave laid lift was brought the hall where it was NA-B stated she washing her hands when she thought	c12 a.m. nursing assistant 28 with toilet use. NA-B was o transfer R128 to the toilet, I lift. NA-B and NA-M had ulled down R128's pants and continent briefs, which were ad bowel movement, and threw page can. NA-B removed the he bathroom, using the same B removed gloves and put on put a new incontinent brief on the stand-aid lift, hooked up the sable washcloths. NA-B and pulled up R128's perineum and pulled up R128's pants. To his easy chair/recliner for a leg rest was put up, a blanket personal alarm was put on R128 his call light. The stand to out of R128's room and down as put into a room to store. The stand are usually very good about about where the sanitizer was, robably hadn't washed or				

F 441 Continued From page 44 sanitized her hands between glove changes. On 10/26/16, at 2:40 p.m. the DON stated staff should wash hands before donning gloves, sanitize or wash hands between glove changes, and after. The undated facility policy and procedure for Handwashing/hand Hygiene directed staff to wash or sanitize hands before and after direct contact with residents, after removing gloves, and indicated the use of gloves does not replace the hand washing or hand hygiene. F 465 SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced F 461 CROSS-REFERENCED TO THE APPROPRIATE DEFINITION. F 441 Responsible Person: DON F 465-E Corrective Action: A. Room 204 door protector repaired, fixed molding, added mud to wall, and painted. B. Replaced the commode in room 222. C. Bathroom tile in 237 was scrubbed clean. D. In room 248 the door frames were painted and the holes in floor were patched. E. The wheelchair in room 252 was washed, tape was removed, and new tape applied. F. The wheelchair in room 259 had both arm rests replaced. G. Carpet in room 263 was shampooed and re-glued. Carpet	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
BAYSHORE RESIDENCE & REHAB CTR			245227	B. WING		10/2	7/2016
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			EHAB CTR	10	601 ST LOUIS AVENUE		
sanitized her hands between glove changes. On 10/26/16, at 2:40 p.m. the DON stated staff should wash hands before donning gloves, sanitize or wash hands between glove changes, and after. The undated facility policy and procedure for Handwashing/hand Hygiene directed staff to wash or sanitize hands before and after direct contact with residents, after removing gloves, and indicated the use of gloves does not replace the hand washing or hand hygiene. F 465 SS=E S=E F 465 F 46	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE	(X5) COMPLETION DATE
Based on observation, interview, and document review, the facility failed to maintain a safe, clean and homelike environment in 8 of 40 resident room (Rooms 204, 222, 237, 248, 252, 259, 263, 264). Findings include: On 10/27/16, at 9:45 a.m. during an environmental tour with the maintenance supervisor (MS), the housekeeping director (HD) and the administrator the following environmental findings were verified: Min the replace with hard striate flooring by 12/14/16. H. The bathroom has been sanitized and the grout has been scrubbed clean in room 264. Corrective Action as it applies to other Residents: A. The Environmental policy has been implemented. B. The facility has reviewed and revised Environmental Services checklist.	F 465	sanitized her hands On 10/26/16, at 2:4 should wash hands sanitize or wash ha and after. The undated facility Handwashing/hand wash or sanitize ha contact with reside indicated the use o hand washing or ha 483.70(h) SAFE/FUNCTION/E ENVIRON The facility must pr sanitary, and comforesidents, staff and This REQUIREMED by: Based on observate review, the facility from (Rooms 204, 264). Findings include: On 10/27/16, at 9:4 environmental tour supervisor (MS), the and the administration of the standard standard supervisor (MS), the and the administration of the standard supervisor (MS), the and the administration of the standard standard supervisor (MS), the and the administration of the standard supervisor (MS), the and the administration of the standard supervisor (MS), the and the administration of the standard supervisor (MS), the and the administration of the standard supervisor (MS), the standard supervisor (MS) and the standard supervisor (MS), the standard supervisor (MS) and the sta	between glove changes. O p.m. the DON stated staff before donning gloves, ands between glove changes, o policy and procedure for Hygiene directed staff to ands before and after direct ats, after removing gloves, and f gloves does not replace the and hygiene. AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for the public. NT is not met as evidenced tion, interview, and document ailed to maintain a safe, clean conment in 8 of 40 resident 222, 237, 248, 252, 259, 263, and the maintenance are housekeeping director (HD) tor the following environmental		F 465-E Corrective Action: A. Room 204 door protector refixed molding, added mud to and painted. B. Replaced the commode in received. C. Bathroom tile in 237 was so clean. D. In room 248 the door frame painted and the holes in floor patched. E. The wheelchair in room 252 washed, tape was removed, new tape applied. F. The wheelchair in room 253 both arm rests replaced. G. Carpet in room 263 was shampooed and re-glued. Co will be replaced with hard selfooring by 12/14/16. H. The bathroom has been same and the grout has been scrul clean in room 264. Corrective Action as it applies to oth Residents: A. The Environmental policy he implemented. B. The facility has reviewed an revised Environmental Serversed.	to wall, room crubbed es were or were 2 was and 9 had Carpet surface itized bbed her has been	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245227	B. WING		10/:	27/2016	
	RE RESIDENCE & RE	EHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CO 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 465	the bottom was chip by 2 inches causing entry at the bottom molding was missin chipped. Room 222, the fron the toilet, were rust half the way up. Room 237, the bath coating as if chipped. Room 248, the bath were scuffed. The bath were scuffed. The bath were scuffed. The bath with inserts which with inserts which with inserts which with inserts are of different and worn. Room 252, the wheelectrical tape of different and worn. Room 259, the left several long tears. Room 263, the carp was stained and look. Room 264, the bath floor grout in the bath floor grout in the bath appeared dirty. The MS and the HE assistants (NA) were wheelchairs to the work wheelchairs were a when a resident dis	m door on the inside edge at oped approximately 4 inches a sharp surface. At the room edge outside the door the edge outside the door the edge and the sheetrock was at legs of the commode over you the bottom approximately aroom floor tile had a white dor rubbed off. Throom and room door frames bathroom floor had small holes were filled with dirt. The elchair was dirty and had efferent colors that were frayed wheelchair arm rest had the open in the center of the room onese. Throom smelled of urine and the throom was dark and Distated the night nursing the totake resident's wheelchair washer. The facility had a mat maintains a schedule for you staff can make a	F 4	Pate of Completion: December Recurrence will be prevented A. All Staff will be educexpectations to proving functioning, sanitary comfortable environmentall-staff meetings convected by the same of 10-28-16. B. Facility will perform per week for 2 weeks audits for 4 weeks, the same of the QAPI for review and follow recommendations. To Committee will deter audits may be discontrolled. Responsible Person: Administration of the province of the person of the perso	by: cated on the ide a safe, , and ment through mpleted the audits 4x's s, then weekly nen monthly x will be Committee v up The QAPI rmine when the tinued.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/	27/2016
	PROVIDER OR SUPPLIER RE RESIDENCE & RE	EHAB CTR		10	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	stated 10 rooms we	ge 46 est for repairs. The MS further ere audited every week. sted but not provided.	F4	165			
:				The state of the s			
		·		a property of the second secon			

PRINTED: 11/09/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245227 B. WING 10/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1601 ST LOUIS AVENUE BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 FIRE SAFETY APPROVED The I Sul THE FACILITY'S POC WILL SERVE AS YOUR By Tom Linhoff at 8:47 am, Dec 12, 2016 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 substantial compliance with the requirements for participation in Medicare/Medicald at 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF = 9 ~2016CORRECTION FOR THE FIRE SAFETY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

DEFICIENCIES (K TAGS) TO:

Healthcare Fire Inspections

State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR

Executive Sirector

M DEPT. OF PUBLIC SAFETY

E FIRE MARSHAL DIVISION

(X6) DATE

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245227	B. WING		120	10/	25/2016
	PROVIDER OR SUPPLIER	EHAB CTR		18	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULI. SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici	tate.mn.us @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION: what has been, or will be, done ency.	K	0000			
	3. The name and/or responsible for corr prevent a reoccurre Bayshore Health Ca a no basement. The constructed in 1969 original building bui Type II (111) constructed as o The building is fully facility has a comples moke detection in that is monitored for notification. The facility has a lice	The facility has a licensed capacity of 139 beds and had a census of 107 at the time of the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245227	B. WING			10/2	25/2016
	PROVIDER OR SUPPLIER	EHAB CTR		16	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000 K 018 SS=E	The requirement at NOT MET as evide NFPA 101 LIFE SA Doors protecting corequired enclosure hazardous areas stas those constructs core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist the no impediment to topen devices that in pushed or pulled a provided with a medoor closed. Dutch permitted. Door framade of steel or of with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Based on observating had 2 of several control to the requirements of Code" 2000 edition deficient practice of as well as an under visitors if smoke from the exit access confindings include: On facility tour bet on 10/25/2016, ob	42 CFR Subpart 483.70(a) is	K	0000	K 018- E Corrective Action: A. Room 200 and 239 have been adjusted to close and latch properly. Corrective Action as it applies to the efacility: A. All doors within the facility with the checked to assure proper closs. Date of Completion: December 8, 20 Responsible Person: Maintenance Direction of the control of the	entire were sure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245227	B. WING			10/25/2016	
	ROVIDER OR SUPPLIER	EHAB CTR		160	REET ADDRESS, CITY, STATE, ZIP CODE 01 ST LOUIS AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 018	Continued From pa that did not fully clo frames.	age 3 ase and latch into the door	Κo	18			
K 056 SS=F	Maintenance Supe NFPA 101 LIFE SA Where required by facilities shall be prapproved, supervisin accordance with systems are equipply switches which are the building fire alla construction, alternshall be permitted protection in specific regulations prohibin NPFA 13 This STANDARD Based on observate facility faille to ensistent in installed 101 "The Life Safe section 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are section 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are section 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are sections 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are sections 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are sections 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are section 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are section 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are section 19.3.5.1 are for the Installation edition sections 5-condition is causin protection system emergency that controls are section 19.3.5.1 are for the Installation edition sections 5-condition is causing protection system emergency that controls are section 19.3.5.1 are for the Installation edition sections 5-condition is causing protection system emergency that controls are section 19.3.5.1 are for the Installation edition sections 5-condition is causing protection system emergency that controls are section 19.3.5.1 are for the Installation edition section is causing protection in the Installation edition is causing protection in the Installation edition	ition was verified by a rvisor. AFETY CODE STANDARD section 19.1.6, Health care rotected throughout by an sed automatic sprinkler system section 9.7. Required sprinkler ped with water flow and tamper electrically interconnected to arm. In Type I and II native protection measures to be substituted for sprinkler fic areas where State or local transprinklers. 19.3.5, 19.3.5.1, is not met as evidenced by: ations and staff interview, the cure that the automatic sprinkler in accordance with the NFPA by Code" 2000 edition (LSC) and the NFPA 13 "The Standard of Sprinkler Systems" 1999 4 and 5-5. This deficient a decrease in the fire capability in the event of an ould affect 55 of 107 residents, etermined number of staff, and	K	056	K 056- F Corrective Action: A. Sprinkler heads in the main exceptionist area were switch by fire protection vendor so a heads are the same response. Corrective Actions as it applies to the facility: A. All fire compartments were assessed to assure there are mixed action sprinkler heads a compartment. Date of Completion: December 8, 20 Responsible Person: Maintenance Di	ed out all action. entire no within	
	Findings include:						

	The state of the s			LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
ė.		245227	B. WING	<u> </u>	10/2	25/2016	
	PROVIDER OR SUPPLIE,			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 056	On facility tour be on 10/25/2016, of revealed that their response fire spri	otween 11:00 a.m. to 2:00 p.m. oservation and staff interviews are are standard and quick inkler heads mixed in the same it is located at the main entry	K 056			7.	
	This deficient cor Maintenance Sup	ndition was verified by a pervisor.				8	
7							



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 3020 0001 8869 1494

November 10, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5227027

Dear Mr. Uselman:

The above facility was surveyed on October 24, 2016 through October 27, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Bayshore Residence & Rehab Ctr November 10, 2016 Page 2

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

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

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: <u>Teresa.Ament@state.mn.us</u>

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Teresa at (218) 302-6151.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00589		B. WING		10/2	7/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
BAYSHO	RE RESIDENCE & RE	HAB CTR		OUIS AVENI MN 55802	JE .		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L:		ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION	ORDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ction order has y. If, upon reins iency or deficience or d	been issued spection, it is notices cited each violation accordance ed by rule of th. In has been all at the tag cated below. Se, failure to be considered iance upon part rule will				
	that was violated du corrected.						
	You may request a that may result from orders provided that the Department with notice of assessme	n non-compliand It a written requ hin 15 days of r	ce with these est is made to eceipt of a				
	INITIAL COMMENT On October 24, 201 surveyors of this De above provider and orders are issued. completed, please s these orders and re Minnesota Departm	the following the following contraction of the following contraction of the following contraction of the following	if, visited the orrection ons are nake a copy of I to the		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. I to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
		00589	B. WING		10/27/2016
	PROVIDER OR SUPPLIER	1601.9	ADDRESS, CITY,	STATE, ZIP CODE	
BAYSHO	RE RESIDENCE & RE	FHAB CTR	TH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
2 000	Continued From pa	ge 1	2 000		
	Compliance Monito Certification Progra Suite 290, Duluth, M	m; 11 East Superior Street,		The assigned tag number appear far left column entitled "ID Prefix The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replace Comply" portion of the correction This column also includes the fine which are in violation of the state after the statement, "This Rule is as evidence by." Following the sufindings are the Suggested Methodorrection and Time period for Correction and Time period for Correction and Time period for Correction." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA SETTING TO THE SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA SETTING THE SUBMIT A PLAN OF	Tag." bliance is t of es the "To order. dings statute not met rveyors od of orrection. DING OF I F TO C. THIS
2 565	MN Rule 4658.0408	5 Subp. 3 Comprehensive	2 565	STATUTES/RULES.	
	Subp. 3. Use. A co	omprehensive plan of care I personnel involved in the i.			
	by: Based on observati	ent is not met as evidenced ion, interview and document ailed to accommodate bathin			

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 2 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00589		B. WING		10/2	27/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR		OUIS AVENI MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	'	•		2 565			
	preferences as dire residents (R15) rev addition, the facility for toilet use was fo (R128) reviewed for	iewed for bathing failed to ensure Illowed for 1 of 3	g choices. In the care plan				
	Findings include:						
	R15's Diagnosis Re R15's diagnoses inc pulmonary disease diabetic neuropathy	cluded chronic o (COPD), diabete	bstructive es with				
	The quarterly Minim 10/6/16, indicated F had no behaviors o further indicated R1 with bed mobility, tr personal hygiene. T was occasionally in indicated bathing di assessment period. 7/7/16, indicated R bathing, and it was choose between a t sponge bath.	R15 was cognitived rejection of care rejection of care 5 required staff ansfers, dressing the MDS also independent of bladed not occur during. The annual MD required assistery important for	ely intact, and es. The MDS assistance g and dicated R15 lder. The MDS as the Stance with or R15 to				
	The care plan revis required the extens bathing (including to shower chair). The guide updated on 9 the bath list for bath Schedule updated of was scheduled for a Saturday on the after	ive assistance or ransfer assistand nursing assistan /23/16, directed n days. The Wee on 10/25/16, indi- a shower on Tue	f one staff for ce to the t (NA) care staff to see kly Shower cated R15				
	The facility's Showe Sheet Update forms 10/18/16, indicated	s from 9/3/16, the	rough				

Minnesota Department of Health

STATE FORM 992W11 If continuation sheet 3 of 46

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589	B. WING		10/2	7/2016
	PROVIDER OR SUPPLIER DRE RESIDENCE & RI	FHAB CTR 1601 ST L	DRESS, CITY, S OUIS AVENI MN 55802	STATE, ZIP CODE UE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	shower, R15 had o did refuse a showe the worksheet indicate the shower becaus available, and they During observation through 10/27/16, a appeared messy ar On 10/25/16, at 8:5 over a month since R15 stated staff tell his shower. R15 furshower a couple of shower day was Samore frequent shows hower on Tuesday shower on any day, my hair every day if On 10/27/16, at 2:2 administrator (TMA unable to get the affect were only two nursi unit, with a float NA On 10/27/16, 2:30 p (LPN)-A stated R15 because he stayed day. R15 refused if R15 was scheduled Saturday in the after find documentation On 10/27/16, at 2:4 worked afternoons she had never had	nly received 3 showers. R15 r on 9/24/16, and on 10/15/16 rated staff was unable to do e there was not enough staff were trying to train new staff. from 10/25/16, at 8:57 a.m. at 2:00 p.m. R15's hair and slightly greasy. 7 a.m. R15 stated it had been he had received a shower. I him there was no time to do other stated he would like a times a week. R15 stated his aturday, and he had requested wers. The facility added a y, R15 felt he did not get a reliable to p.m. trained medication at sticks up all over the place." 80 p.m. trained medication as there and assistants (NA) on R15's a between two units. 9. m. licensed practical nurse or refused the shower at times ap late and would sleep all he was sleepy. LPN-A verified defor a shower on Tuesday and pernoon. LPN-A was unable to	2 565			

Minnesota Department of Health

STATE FORM 992W11 If continuation sheet 4 of 46

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPF IDENTIFICATION		, ,	E CONSTRUCTION		SURVEY PLETED
		00589		B. WING		10/	27/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR		OUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC / MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 4		2 565			
	(DON) verified the	care plan should b	e followed.				
	A policy on following but not provided.	g the care plan wa	s requested				
	R128's Admission Fidentified diagnoses urinary incontinence	s that included der	nentia,				
	R128's admission Mated 10/7/16, indicingular and decision-making. Rewith transfers with transfer	cated R128 had m itive skills for daily 128 required total two staff assist and toilet use. R128's ways incontinent of	assistance d extensive MDS				
	R128's care plan da anticipate and mee communication impindicated R128 was bowel and bladder, and change R128 of for incontinence, ar The care plan furth stand-aid with 2 starequired extensive	t R128's needs, as pairment. The care is frequently inconting and directed staff every 2 hours and change clothing or indicated R128 off assist for transfer	s he has a plan further nent of to check as required as needed. required the ers, and				
	The Nursing Home 10/25/16, directed s hours with assist of with the stand-aid li	staff to toilet R128 2 staff and to tran	every two				
	R128's Bowel and I indicated R128 was and required extens The Bowel and Bla was confused and	s always incontiner sive assistance for dder screener indi	nt of bladder toilet use. cated R128				

6899

Minnesota Department of Health

winneso	ta Department of He	aith					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLI		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NU	JMBER:	A. BUILDING:		COMP	LETED
		00589		B. WING	· · · · · · · · · · · · · · · · · · ·	10/2	7/2016
NAME OF I	PROVIDER OR SUPPLIER	•	STDEET AD	DDESS CITY S	STATE, ZIP CODE	-	
IVAIVIL OI I	HOVIDEN ON SOLVER			OUIS AVEN	•		
BAYSHO	RE RESIDENCE & RE	EHAB CTR		MN 55802	OE .		
	OLIMANA DV. OTA	TEMENT OF DEFIDIENCIE			DDOWDEDIO DI ANI OF CODDECTIO		0.5
(X4) ID PREFIX		TEMENT OF DEFICIENCIE MUST BE PRECEDED BY		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	-	(X5) COMPLETE
TAG		SC IDENTIFYING INFORM		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
2 565	Continued From pa	ige 5		2 565			
	·	_					
	On 10/26/16, at 7:4	28 were initiated who	n B128				
		herapy in a wheelch					
		to watch television. A					
		ught to the dining ro					
		a.m. R128 was broug					
		the common area ar					
		3:50 a.m. R128 was					
		ontinuous observation					
		R128's physical ther					
		 n. certified occupation 					
		A), who had brought					
		on the unit before bre	,				
		ad worked with R12					
		stated she gets at t					
		ed working with him					
		OTA verified she had					
		on toileting. At 9:52 a					
		n physical therapy a vas detected. At 10:					
		oileted R128 when t					
		apy. At 10:07 a.m. th	, ,				
		B down the hall in his					
	•	0 a.m. physical thera					
		in the common area					
		unit. Staff were not i					
	R128 had returned	from therapy.					
		ng assistant (NA)-B					
		om to use the toilet,					
		nitiation of continuou					
		pproximately 3 hours					
		lent was changed wi					
		nerapy the first time. Is removed in the ba					
		ly of urine and also h					
		the brief. NA-B threv					
		A-B verified the brie					
		d BM. NA-B verified					
		d been changed bef					

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 6 of 46

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				71. BOILDING.			
		00589		B. WING		10/2	7/2016
NAME OF F	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR		OUIS AVEN MN 55802	UE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ıge 6		2 565			
	therapy the first tim R128 before therap NA-B stated she us hours.	y took him to	therapy again.				
	On 10/26/16, at 2:4 (DON) verified the						
	SUGGESTED MET The Director of Nur develop, review, an procedures to ensu The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance. TIME PERIOD FOR (21) days.	rsing or design ad/or revise poure care plans rsing or design riate staff on the rsing or design systems to en	nee could olicies and are followed. nee could ne policies and nee could nsure ongoing				
2 800	MN Rule 4658.051 Staffing requirement		sing Personnel;	2 800			
	Subpart 1. Staffing home must have or number of qualified registered nurses, I nursing assistants ir residents at all nursin all buildings if mo involved. This incluand vacation replace	n duty at all tir I nursing pers icensed prac to meet the ne ses' stations, one bre than one budes relief du	nes a sufficient sonnel, including tical nurses, and eeds of the on all floors, and building is				
	This MN Requirem by: Based on observat review, the facility f	ion, interview,	and document				

Minnesota Department of Health

STATE FORM 992W11 If continuation sheet 7 of 46

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
		00589	B. WING		10/2	7/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 10/-	.,
BAYSHO	RE RESIDENCE & RE	-HAB CTR	OUIS AVEN	UE		
		DULUTH,	MN 55802	PROVIDEDIO DI ANI OF CORRECTI	ON	0.4=0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 7	2 800			
	nursing staff was provided in the	rovided for all 108 residents facility.				
	Findings include:					
	provide adequate s	- as the facility failed to taffing to accommodate s for 1 of 3 residents (R15) es.				
	failed to provide co	ncontinence - as the facility nsistent staff assistance with esidents (R128) observed for e.				
	RESIDENT CONCI	ERNS WITH THE LACK OF FING:				
	8/3/16, indicated R totality dependent of transferring and toil a.m. R155 stated the hour for a staff mer R155 stated she staff would final stated the staff see	nimum Data Set (MDS) dated 155 was cognitively intact, was on staff for assistance with leting. On 10/25/16, at 9:50 hat she had waited for over an inber to answer her call light. arted to scream out, and then ly come. In addition, R155 med to be rushed when they ares and that just didn't feel				
	R29 was cognitively therapy. On 10/27/ there was not enou night shift and at tin on who covered bo stated the evening on around 12:30 a. to place his oxygen	S dated 9/27/16, indicated y intact and used oxygen 16, at 10:22 a.m. R29 stated gh nursing assistants on the nes there was only one nurse th floors at the facility. R29 prior he had put his call light m. as R29 required assistance on for the night. R29 stated to 2:00 a.m. (an hour and a half				

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 8 of 46

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	ORE RESIDENCE & RI	-HAB CTR	OUIS AVENI MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 800	later) and placed his he didn't want to fall been placed as he oxygen at night what times the nursing a turn the call light of back, and then they he didn't like when before they address. FAMILY CONCERN ADEQUATE STAFF. When interviewed of family member (FM dependent on staff 10/25/16, during the visiting his wife, she bowel and a nursing needed to get some stated the nursing anyone to help so he before the nursing anyone to help so he stated the staff working it lidin't have time." FM-A stated his heart that she we needed or deserved came the facility to STAFF CONCERN On 10/25/16, at 10: (NA)-A, who also we aide (TMA), stated surveyors were at the fully staffed. NA	s oxygen on him. R29 stated I asleep until the oxygen had needed the supplemental en he slept. R29 stated at ssistants would come in and f and say they would be right of didn't come back. R29 stated the staff turned the call light off sed his needs. IS WITH LACK OF FING: on 10/27/16, at 11:00 a.m. I)-A stated his wife was totally for cares. FM-A stated on e evening shift when he was en had been incontinent of grassistant told FM-A that they en help to clean her up. FM-A assistant wasn't able to find his wife sat in BM for two hours assistants returned to clean dat times he needed to help the secause there wasn't had been incontinent of the secause there wasn't had at times he needed to help the secause there wasn't had been incontined to clean dat times he needed to help the secause there wasn't had been incontined to clean the secause there wasn't had been incontined to clean dat times he needed to help the secause there wasn't had been incontined to clean the felt frustrated and it broke wasn't receiving the care she d. FM-A stated he routinely visit his wife twice a day.	2 800			

Minnesota Department of Health

STATE FORM 99ZW11 If continuation sheet 9 of 46

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA ATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589		B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR		OUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 9		2 800			
	toileted and reposit when she had work the nursing assistal however, then she resident's medication on 10/26/16, at 7:1 had been short staff worked a lot of extra short staffed.	ioned on time and as a TMA, onts out when a was late on a cons. 2 a.m. NA-E a fi lately. NA-E a shifts becaus	she tried to help she could, dministering the stated the facility stated she use they were				
	dressing change or (LPN)-B stated, she facility because the the residents didn't met like being offer when they should be felt that was why th developed pressure septic.	n R18 licensed e continued to y needed her. always get th ed fresh wate be turned. LPN e facility had i	d practical nurse work at the LPN-B stated eir basic needs ar and turned L-B stated she residents that				
	On 10/26/16, at 9:1 she was unable to though the NA's trie during survey time schedule more staf	get her work o ed very hard. I the facility see	completed even NA-F confirmed				
	On 10/26/16, at 10: was hard. NA-B wa locked dementia ur stated she called for she needed to trans	s the only per nit with eight re or help from a	rson on the esidents. NA-B nother unit when				
	On 10/26/16, at 11: needed to be more NA-G stated she w week period she wa an extended shift. I she was not able to	organized at orked full time as mandated i NA-G stated n	the facility. e and every two to stay and work nost of the time				

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 10 of 46

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00589		B. WING		10/2	27/2016
	ROVIDER OR SUPPLIER	EHAB CTR	1601 ST L	DRESS, CITY, S OUIS AVENU MN 55802	STATE, ZIP CODE UE		
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	Continued From particles of the stated she didn't get NA-G stated the resup for themselves or needed, because the staff when they no longer had assistants also had besides completing. On 10/2716, at 8:23 was routinely short was able to comple stayed beyond here when she charted. On 10/27/16, at 9:2 was asked to stay leaver shift she worked mandated to stay of scheduling period. Was more than one mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were incontinent. In her until noon to constated normally she residents, however required two staff on assistants just tried. On 10/27/16, at 9:3 been mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were mandated to stay for one weekend fives shift were were mandated to stay for one weekend fives shift were were mandated to stay for one weekend fives shift were were mandated to stay for one weekend fives shift were were were were were well were wer	I not get repositioney should. In act her charting considers that could have not get the december of the reposition of t	ddition, NA-Gompleted. Id not speak care they to remind the NA-G stated the nursing baths a day es. ated the facility stated she ause she and that was each of the stated the facility stated she ause she and that was each of the day evening shift. It staff members tated things are idents who retimes it took cares. NA-H about 10 re residents rsing am.				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	ORE RESIDENCE & RI	FHAR CTR	OUIS AVENI MN 55802	JE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	orientation. NA-I si enough staff to car stated there were of 36 residents on the residents who were stated she had see because they had I and should have had with the transfer. Not residents who were toileted timely due available. On 10/27/16, at 10 as a TMA, stated who was always pulled assistants. NA-J stated was assigned and medications, provior residents' blood surinsulin. NA-J state one nurse was assigned and medications on. Not get done. NA-Gresidents who were themselves and who was always assistants in the cuntil 1:00 p.m. with changed. NA-J state their baths, especially was always stated two weeks a assistant for 24 resin, and she worked	age 11 tated she felt there were not e for the residents. NA-I only two nursing assistants for a day shift, with only five of the fairly independent. NA-I on staff hurt themselves ifted residents by themselves ad two staff members assisting IA-I stated she was aware of a not turned, repositioned, or to not having enough staff 224 a.m. NA-J, who also works when she worked as a TMA she away to assist the nursing tated when she worked as a two 34 residents which she responsible for passing their ding treatments, monitoring gars, and administering dithere had been times when igned 51 residents to pass IA-J stated resident cares do J stated she was aware of a not able to speak for no required two staff to assist and had sat up in their common area from 7:00 a.m. out being repositioned or ated residents are not getting ally on the second floor units by two nursing assistants for residents. NA-J stated the running short of staff. NA-J ago they only had one nursing aidents, so she called someone as a nursing assistant and the took on NA-J's duties to pass	2 800			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED.

	00589	B. WING	10/27/2016
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE					
BAYSHO	RE RESIDENCE & REHAB CTR	DULUTH,		=			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 800	Continued From page 12		2 800				
	On 10/27/16, at 10:32 a.m. NA-H staresidents who cannot speak up for the put on their call light had not received they needed because there wasn't exprovide the care. On 10/27/16, at 1:18 p.m. interview of with director of nursing (DON), the soft human resource director (HRD). HRI staffing was one of biggest challenge had. DON stated they had asked at the council meetings if the residents had concerns with timeliness of call lights answered. DON stated this had not up as an area of concern by those reattended the resident council. DON of facility had not conducted any type or response time audit. However, the factively advertising their open position confirmed the facility was not using a staff. HRD confirmed the facility curropen licensed staff (RN/LPN) position least ten open nursing assistant positions the staff were good about filling shifts, but everyone needed a break liked to be mandated to stay. Scheduconfirmed in a two week period the fan average, mandating about 10 shift included licensed staff and nursing as st	nemselves or d the care nough staff to conducted cheduler and D stated es the facility he resident any been brought esidents who confirmed the f call light acility was ons. DON any agency ently had five ns, and at tions. DON any in the open and nobody uler acility was on its (this					
	The scheduler confirmed the staffing the facility were: - Day and evening shift = 4 licensed (RN/LPN) and 13 nursing assistants - Night shift = 3 licensed staff (RN/LF nursing assistants	needs for					
	On review of the Nursing Schedules October 2, 2016, through November						

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPFIDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		00589		B. WING		10/	27/2016	
	PROVIDER OR SUPPLIER PRE RESIDENCE & RE	EHAB CTR	1601 ST L	DRESS, CITY, S OUIS AVENU MN 55802	STATE, ZIP CODE JE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 13		2 800				
	the schedules indic	ated the following	open shifts:					
	 Licensed staff (RN/LPN) = 103 shifts Nursing assistants = 154 shifts On review of the facility's Direct Staff Working Hours postings for the last 30 days (9/25/16-10/24/16) the following was reflected: 							
	Day shift (6:00 a.m 2:00 p.m.): * licensed staff (RN/LPN) = short 20 out of 30 days; averaged one licensed staff short per day shift * nursing assistants = short 30/30 days; ranging from 1-5 staff short, with an average or 2 staff short per day shift							
	Evening shift (2 p.m * licensed staff (RN averaged one licenshift	/LPN) = short 20/3						
	* nursing assistants = short 30/30 days; ranging from 1-5 staff short with an average of 3 staff short per evening shift							
	Night shift (10:00 p. * licensed staff (RN averaged one license * nursing assistants from 3-4 staff short short per night shift	/LPN) = short 18/3 sed staff short per s = short 30/30 day with a an average	shift /s: ranged					
	A policy on staffing provided.	was requested an	d none					
	SUGGESTED MET The administrator of revise policies, revi- needs in order to en Education could be	or designee could of the could of the could of the could be could need the could be	review and eduling ds are met.					

Minnesota Department of Health

STATE FORM 992W11 If continuation sheet 14 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
			A. BOILDING.			
		00589	B. WING		10/2	27/2016
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY,			
BAYSHO	RE RESIDENCE & RE	-HARCIR	T LOUIS AVEN H, MN 55802	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 14	2 800			
	auditing system in o	signee could develop an order to ensure compliance. R CORRECTION: Twenty-On	е			
2 910	910 MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence					
	have a continuous management to recunnecessary use of comprehensive reshome must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident where it receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladdeduce incontinence and the f catheters. Based on the ident assessment, a nursing that: The enters a nursing home ag catheter is not catheterized so catheter is not catheterized was necessary; and no is incontinent of bladder the treatment and services to cat infections and to restore as ler function as possible.	3			
	by: Based on observati review the facility fa assistance was pro (R128) reviewed fo Findings include: R128's Admission Fidentified diagnoses	ent is not met as evidenced ion, interview, and document ailed to ensure toileting evided for 1 of 3 residents r incontinence. Record printed 10/26/16, as that included dementia, e, and diverticulosis.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION		:/SUPPLIER/CLIA ATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				7.1. 20.23			
		00589		B. WING		10/2	7/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR		OUIS AVENI MN 55802	JE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910		_		2 910			
	R128's admission Mated 10/7/16, indice impairment of cognitive decision-making. Rewith transfers with transfers	eated R128 ha itive skills for 128 required wo staff assis toilet use. R12 ways incontin	ad moderate daily total assistance at and extensive 28's MDS				
	R128's care plan dated 10/7/16, directed staff to anticipate and meet R128's needs, as he has a communication impairment. The care plan further indicated R128 was frequently incontinent of bowel and bladder, and directed staff to check and change R128 every 2 hours and as required for incontinence, and change clothing as needed. The care plan further indicated R128 required the stand-aid with 2 staff assist for transfers, and required extensive assist of 2 staff for toilet use.						
	The Nursing Home Assignment Sheet updated 10/25/16, directed staff to toilet R128 every two hours with assist of 2 staff and to transfer R128 with the stand-aid lift.						
	R128's Bowel and I indicated R128 was and required extens The Bowel and Bla was confused and I	always incor sive assistand dder screene	ntinent of bladder be for toilet use. r indicated R128				
	On 10/26/16, at 7:4 observations of R12 was brought from the unit common area to a.m. R128 was broughted breakfast. At 8:30 at the dining room to the TV. At 8 physical therapy. C	28 were initiat nerapy in a who watch televught to the dirum. R128 was he common as:50 a.m. R12	need when R128 neelchair, to the ision. At 7:56 ning room for s brought from area and set in 8 was brought to				

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 16 of 46

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00589		B. WING		10/2	27/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 10/-	
BAYSHO	RE RESIDENCE & RE	EHAB CTR		OUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	continued through I session. At 9:11 a.r therapy aide (COTA the common area of noted, stated she had at 6 a.m. and started body cares. The CO worked with R128 of continued to work in incontinence odor of COTA stated staff thim up prior to ther therapist took R128 wheelchair. At 10:1 R128's wheelchair. At 10:1 R128's wheelchair the TV and left the R128 had returned At 10:12 a.m. nursi R128 to his bathrood 1/2 hours since in observations and a minutes since resid was gotten up for the incontinent brief was and smelled strong movement (BM) in into the garbage. Now soiled with urine an incontinent brief had therapy the first tim R128 before therapy NA-B stated she us hours. On 10/26/16, at 2:4	R128's physical certified of A), who had be an the unit be ad worked with stated she ged working with DTA verified so to toileting. An physical the was detected. Oileted R128 apy. At 10:078 down the had 0 a.m. physical the commounit. Staff we from the rapy assistant (om to use the nitiation of corpproximately lent was charmerapy the first semoved in ly of urine anothe brief. NAA-B verified to d BM. NA-B of d been change, and she had been change, and she had been change.	ccupational prought R128 to fore breakfast, as ith R128 for 70 gets at the facility th him on upper she had not at 9:52 a.m. R128 grapy and a slight. At 10:06 a.m. when they got a.m. the physical all in his cal therapist set on area in front of the renot informed at the collet, which was not all the bett time. R128's at the bathroom d also had boweld be the brief was verified R128's ged before ad not toileted otherapy again. This prought a toilet was verified R128's ged before ad not toileted otherapy again. This process are the colleted of the process and the process are the colleted of the process and the process are the process are the process are the process and the process are the process are the process are the process and the process are the process are the process are the process are the process and the process are the process	2 910			
	(DON) stated R128 every 2 hours and vibe followed.	should be of	ffered toilet use				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.25.1143.			
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	FHAR CIR	OUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	age 17	2 910			
	for toilet use was n SUGGESTED MET director of nursing develop and impler residents were toile comprehensive ass The DON or design appropriate staff. T monitor this proces compliance.	THOD OF CORRECTION: The (DON) or designee could ment systems to ensure				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.					
	by: Based on observat review, the facility f an ongoing, compresurveillance progra trending of infection effect all 108 reside In addition, the faci injectable pens wer prevent cross conta pathogens for 16 o pens in the medica	ent is not met as evidenced ion, interview and document ailed to develop and maintain ehensive infection control am related to the tracking and hs. This had the potential to ents who resided in the facility. lity failed to ensure insuling restored in a manner to amination of blood-borne of 16 residents who had insuling tion cart on all 5 units. In a failed to ensure appropriate				

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 18 of 46

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00589		B. WING		10/2	27/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR		OUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 18		21375			
	hand hygiene practices were maintained while assisting 1 of 3 residents (R128) reviewed for toilet use.						
	Findings include:						
	On 10/27/16, at 2:10 p.m. the director of nursing (DON) was interviewed and confirmed that he was responsible for the infection control problem. The DON verified the facility lacked a system for identifying and tracking resident infections. The DON also stated there is not a surveillance program in place to include monitoring of any infection/ infection identification, culture prior to antibiotic initiation, and tracking. The DON stated the infection control program was in it's infancy. There were no infection control logs to review. The facility was unable to provide a policy on infection control prevention and surveillance.						
	On 10/26/16, from medication carts or pens for a total of 1 together in the sam cart, without separate verified that there is of blood borne path pens together.	n each unit co 6 residents the e containers/ ation from each s a risk of cro	ontained insulin hat were stored /bin or area of the ch other. RN-C ss-contamination				
	R10's physician ord R10 had orders for Lantus and Novolog medication cart/bin	Lantus insuli g insulin pens	n. R10 had				
	R117's signed phys Lantus and Humalo and Novolog insulir cart/bin.	og insulin. R1	17 had Lantus				

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	FHAR CTR	OUIS AVEN MN 55802	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 19	21375			
	indicated R97 had	cian orders dated 10/24/16, orders for Lantus and Novolog Novolog insulin pen in the				
	R152's signed physician orders dated 10/24/16, indicated R152 had orders for Detemir and Novolog insulin. R152 had Novolog insulin pens in the medication cart/bin. R13's signed physician orders dated 9/7/16, indicated R13 had orders for Lantus and Novolog insulin. R13 had Novolog and Lantus pens in the medication cart/bin.					
	R155's signed physician orders dated 10/17/16, indicated R155 had orders for Humalog and Lantus. R155 had Humalog and Lantus pens in the medication cart/bin.					
	R15's signed physician orders dated 9/27/16, indicated R15 had orders for Lantus, Aspart and Liraglutide Insulin. R15 had a Victoza pen in the medication cart/bin.					
	indicated R146 had	sician orders dated 9/10/16, I orders for Lantus and 46 had Lantus and Novolog tion cart/bin.				
	indicated R44 had	cian orders dated 9/7/16, orders for Humalog and had Humalog and Lantus tion cart/bin.				
	R14 had Lantus an medication cart/bin	d Novolog insulin pens in the .				
		an orders dated 9/7/16,				

Minnesota Department of Health

STATE FORM 992W11 If continuation sheet 20 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00589	B. WING		10/	27/2016	
NAME OF PROVIDER OR SUPPLIES BAYSHORE RESIDENCE & F	REHAB CTR 1601 ST	ADDRESS, CITY, S LOUIS AVENU H, MN 55802				
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
in the medication R100's signed physindicated R100 had cart/bin. R46's signed physindicated R46 had insulin. R46 had timedication cart/bin. R30's signed physindicated R30 had insulin. R30 had L cart/bin. R200's signed physindicated R200 had R200 had a Lantucart/bin. R18's signed physindicated R30 had Lantus insulin. R1 insulin pens in the On 10/26/16, at 11 (DON) directed the separate plastic be anti-microbial wiper DON instructed the insulin pens with the appropriate of the pension of the separate plastic beautinessed in the insulin pens with the appropriate pension of the separate plastic beautinessed in the insulin pens with the appropriate pension of the separate plastic beautinessed in the insulin pension of the separate plastic beautinessed in the insulin pension of the separate plastic beautinessed in the insulin pension of the separate plastic beautinessed in the separate plasti	untus and Novolog insulin pens cart/bin. ysician orders dated 9/15/16, ad orders for Lantus and Novoli a Lantus pen in the medication sician orders dated 10/17/16, d orders for Lantus and Novologwo Lantus insulin pens in the	g g g				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	-HAB CTR	OUIS AVEN	JE		
0(0.15	CLIMMA DV CTA	·	MN 55802	DDOVIDEDIS DI AN OF CORDECTIO		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 21	21375			
	(NA)-B assisted R1 assisted by NA-M tusing the stand-aid gloves on. NA-B puremoved R128's independent of the soiled with urine and the brief in the gark stand-aid lift from the gloved hands. NA-B puremoved hands. NA-B puremoved gloves. NA-B puremoved gloves and R128 was brought rest, the recliner's limited was put on, and a pure R128. NA-B gave Paid lift was brought the hall where it was put on, and a pure R128. NA-B gave Paid lift was brought the hall where it was named washing her hands when she thought as he realized she pure sanitized her hands sanitize or wash had and after. The undated facility Handwashing/hand wash or sanitize had contact with resider	12 a.m. nursing assistant 28 with toilet use. NA-B was a transfer R128 to the toilet, lift. NA-B and NA-M had alled down R128's pants and continent briefs, which were d bowel movement, and threw age can. NA-B removed the ne bathroom, using the same B removed gloves and put on out a new incontinent brief on e stand-aid lift, hooked up the wiped R128's perineum and sable washcloths. NA-B d pulled up R128's pants. To his easy chair/recliner for a seg rest was put up, a blanket personal alarm was put on R128 his call light. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's room and down so put into a room to store. The stand out of R128's pants. The stand				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00589	B. WING		10/	27/2016
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	DDRESS CITY S	STATE, ZIP CODE	1 10//	27/2010
		1601 ST	LOUIS AVEN			
вауънс	RE RESIDENCE & RE	DULUTI	H, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 22	21375			
21426	director of nursing of review, and/or revise ensure an infection implementation. The designee could edut the policies and pronursing or designee systems to ensure of TIME PERIOD FOR (21) days.	THOD OF CORRECTION: The presence of the policies and procedures to control program that includes the director of nursing or locate all appropriate staff on procedures. The director of the could develop monitoring tongoing compliance. R CORRECTION: Twenty-on A.04 Subd. 3 Tuberculosis	3			
21420	(a) A nursing home maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volui Health shall provide regarding implement (b) Written compliable maintained by the	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of e technical assistance intation of the guidelines.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER STREET ADDRIESS, CITY, STATE, JP CODE 101 ST LOUIS AVENUE DULUTH, MN 55802 FROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST SE PRECEDED BY PULL, MN 55802 FROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS REFERENCED TO THE APPROPRIATE DY Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) baseline screening and tuberculin skin test (TST) was completed for 5 of 5 residents (R83, R129, R135, R143, R145) and 4 of 5 employees (E-A, E-B, E-O, E-D, E-E) according the Centers for Disease Control and Prevention (CDC) guidelines. Findings include: The CDC guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening should consist of assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. R83 was admitted to the facility on 5/10/16. No baseline TB screening was completed. R83's electronic medical record (EMR), indicated R83'r ceived the first step TST on 5/10/16. The first step TST was read on 5/17/16, as negative with 0 millimeter (mm) induration. R83 did not receive a second step test. R129 was admitted to the facility on 6/6/16. No baseline TB screening was completed. R129's EMR indicated R129's exercined the first step TST on 6/6/16, (1) days after administration) the first step TST was read as negative with 0 mm induration. R129's second step TST was administered 6/20/16, and was not read.	-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
A			00589	B. WING		10/2	27/2016	
PASTROPHE RESIDENCE & REHAB CTH DULUTH, MN 55802	NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) 21426 Continued From page 23 by: Based on interview and document review, the facility fullerculosis (TB) baseline screening and tuberculosis (TB) baseline screening screening the Transmission of Mycobacterium Tuberculosis in Health Care Settings, 2005, directed that all residents must receive a baseline TB screening should consist of assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. R83 was admitted to the facility on 5/10/16. No baseline TB screening was completed. R83's electronic medical record (EMR), indicated R83 received the first step TST on 5/10/16. The first step TST was read an 5/17/16/16, as negative with 0 millimeter (mm) induration. R83 did not receive a second step test. R129 was admitted to the facility on 6/6/16. No baseline TB screening was completed. R129's EMR indicated R129 received the first step TST was read as negative with 0 millimiduration. R129's second step TST was administered 6/20/16, and was not	BAYSHO	RE RESIDENCE & RI	FHAR CTR		UE			
by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) baseline screening and tuberculin skin test (TST) was completed for 5 of 5 residents (R83, R129, R135, R143, R145) and 4 of 5 employees (E-A, E-B, E-C, E-D, E-E) according the Centers for Disease Control and Prevention (CDC) guidelines. Findings include: The CDC guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history; assessment for rournet symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. R83 was admitted to the facility on 5/10/16. No baseline TB screening was completed. R83's electronic medical record (EMR), indicated R83 received the first step TST on 5/10/16. The first step TST on 5/10/16. The first step TST on 6/6/16. No baseline TB screening was completed. R129's EMR indicated R129 received the first step TST on 6/6/16. No baseline TB screening was completed. R129's EMR indicated R129 received the first step TST on 6/6/16. No does not step test. R129 was admitted to the facility on 6/6/16. No baseline TB screening was completed. R129's EMR indicated R129 received the first step TST on 6/6/16. No does not step TST was read as negative with 0 mm induration. R129's second step TST was administered 6/20/16, and was not	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	COMPLETE	
R135 was admitted to the facility on 4/26/16. No	21426	by: Based on interview facility failed to ens baseline screening was completed for R135, R143, R145, E-B, E-C, E-D, E-E Disease Control and guidelines. Findings include: The CDC guideline Transmission of My Health Care Setting residents must record the baseline TB screened testing for the process of the	and document review, the sure a facility tuberculosis (TE) and tuberculin skin test (TS) 5 of 5 residents (R83, R129,) and 4 of 5 employees (E-A, E) according the Centers for and Prevention (CDC) ses for Preventing the ycobacterium Tuberculosis in gs, 2005, directed that all eive a baseline TB screening creening should consist of 3 risk factors and history; rrent symptoms of active TB; presence of infection with perculosis. to the facility on 5/10/16. No ning was completed. R83's record (EMR), indicated R83 tep TST on 5/10/16. The first at on 5/17/16, as negative with duration. R83 did not receive to the facility on 6/6/16. No ning was completed. R129's 29 received the first step TST was read as a induration. R129's second inistered 6/20/16, and was no first step decorations.	O a ot				

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 24 of 46

Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00589		B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR		OUIS AVENU MN 55802	UE .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMA"	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	EMR indicated R 13 on 4/26/16, and wa receive a second standard R143 was admitted baseline TB screen EMR indicated R 14 on 7/13/16. On 7/15 read as negative widocumentation. On TST was administe two TST was read a induration. R145 was admitted baseline TB screen EMR indicated she 7/27/16, and was received an addition this was read as uninduration . R 145 or TST. E-A who was hired screening was comwas administered of E-A did not receive E-B who was hired screening was comwas administered of E-B did not receive E-C who was hired screening was comwas administered of E-B did not receive E-C who was hired screening was comwas administered of E-B did not receive E-C who was hired	ing was completed. F 35 received the first s s not read. R 135 did ep TST. to the facility on 7/12 ing was completed. F 43 received the first s 5/16, the first step TS	tep TST not 2/16. No R143's tep TST T was ond step 3's step m of 6/16. No R145's or TST on R145 8/10/16, h 5 mm nd step dine TB p TST ot read. ine TB p TST ot read.	21426	DEFICIENCY)		
		nistered on 8/23/16, a ved a second step TS ead.					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	10/2	1/2010
BAYSHO	RE RESIDENCE & RI	FHAR CTR	OUIS AVEN	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	E-D who was hired screening complete administered 8/1/16 not receive a secon E-E who was hired screening complete TST was completed the first step TST was not be Toleron and a surveillance of resident TST infection, and an addition, when read confirm that the TS 48-72 hours prior to the TST must be read in minust be rea	on 8/1/16. No baseline TB ed. E-D's first step TST was 6, and was not read. E-D did not step TST. on 8/23/16. Baseline TB ed on 10/19/16. E-E's first step d on 10/19/16. On 10/21/16, was read as 0 mm induration, ot receive a second step TST. 0 p.m. the director of nursing wed. The DON verified the TB eing completed. culosis Infection Control dated) directed screening and dents and employees for latent ctive TB as appropriate. In ding the TST, staff should T had been administered or reading. The second step of epeated within 1-3 weeks after TST was read. All test results				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	FHAR CTR	LOUIS AVEN , MN 55802	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	ige 26	21610			
21610	MN Rule 4658.1346 and Preparation Are	0 Subp. 1 Medicine Cabinet ea;Storage	21610			
	must store all drugs under proper tempe	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens had labels with directions for 16 of 16 (R10, R117, R97, R152, R13, R155, R15, R146, R44, R14, R1, R100, R46, R30, R200, R18) residents who used insulin pens. In addition, the facility failed to ensure fentanyl patches were properly destroyed to prevent diversion on 5 of 5 units.					
	Finding include:					
	medication carts or pens for a total of 1 labeled with direction	11:49 a.m. through 12:29 a.m. neach unit contained insulin 6 residents that were not ons for use. The insulin pens with resident names.				
	indicated R10 had	cian orders dated 10/5/15, orders for Lantus and Novolog intus and Novolog insulin pens art.				
	Lantus and Humalo	sician orders dated 10/17/16, og insulin. R117 had Lantus n pens in the medication cart.				
	indicated R97 had	cian orders dated 10/24/16, orders for Lantus and Novolog Novolog insulin pen in the				

Minnesota Department of Health

STATE FORM 992W11 If continuation sheet 27 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/ IDENTIFICAT	SUPPLIER/CLIA TION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589		B. WING		10/2	7/2016
	PROVIDER OR SUPPLIER			DRESS, CITY, § . OUIS AVEN !	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR		MN 55802	-		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 27		21610			
	medication cart.						
	R152's signed physindicated R152 had Novolog insulin. R1 in the medication calls.	l orders for De 52 had Novold	temir and				
	R13's signed physic indicated R13 had insulin. R13 had No medication cart.	orders for Lant	tus and Novolog				
	R155's signed physindicated R155 had Lantus. R155 had the medication cart	l orders for Hu Humalog and L	malog and				
	R15's signed physic indicated R15 had Liraglutide Insulin. medication cart.	orders for Lant	tus, Aspart and				
	R146's signed physindicated R146 had Novolog insulin. R1 pens in the medica	l orders for Lai 46 had Lantus	ntus and				
	R44's signed physic indicated R44 had of Lantus insulin. R44 pens in the medica	orders for Hum had Humalog	nalog and				
	R41 had Lantus an medication cart.	d Novolog inst	ulin pens in the				
	R1's signed physici indicated R1 had or insulin. R1 had Lan in the medication can	rders for Lantu tus and Novol	is and Novolog				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER IDENTIFICA	/SUPPLIER/CLIA TION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				B. WING			NT/00/40
		00589		b. WING		10/2	27/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	EHAB CTR		OUIS AVENI MN 55802	JE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	ige 28		21610			
	R100's signed physician orders dated 9/15/16, indicated R100 had orders for Lantus and Novolin insulin. R100 had a Lantus pen in the medication cart.						
	R46's signed physic indicated R46 had insulin. R46 had two medication cart.	orders for Lan	tus and Novolog				
	R30's signed physic indicated R30 had insulin. R30 had La medication cart.	orders for Lan	tus and Novolog				
	R200's signed physindicated R200 had a Lantus cart.	d orders for La	ntus insulin.				
	R18's signed physic indicated R30 had Lantus insulin. R18 the medication cart	orders for Hur had Humalog	nalog and				
	On 10/26/16, at 12: (RN)-C verified the directions for use of RN-C stated the inspharmacy in bags of box. RN-C stated thrown away after the first use.	re were no lab on any of the ir sulin pens wer or boxes with I d the bag or b	els with sulin pens. e sent from the abels on the bag ox had been				
	On 10/26/16, at 1:0 pharmacist stated t label with directions container it is store	the insulin pen s for use on th	s should have a				
	On 10/27/16, at 3:4	2 p.m. the dire	ector of nursing				

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 29 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00589	B. WING		10/	27/2016
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
BAYSHO	ORE RESIDENCE & RE	HAB CTR	LOUIS AVENU I, MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21610	(DON) verified insuproper labels with opackage or pen. On 10/26/16, at 12: patches (a narcotic were disposed of incontainer used for the Sharps containers were disposed of incontainer used for the Sharps containers were sidents, visitors, as sharps containers were unattended in the homology of the Sharps containers were detailed in the homology of the Sharps containers were detailed in the sewer pharmacist stated the followed for destruction for the disposed of the Sharps container were detailed in the homology of the Sharps container were detailed in the hallway, counter in the hallway, counter in the hallway, counter in the room open. LPN-A verifier room to read the containers may be they were brought of area located outside agency/disprontainers up from the same disposed of the same disposed	lin pens should have the lirections for use on each 38 p.m. RN-C stated fentanyl pain medicated skin patch) the sharps containers (a che storage of used needles). Were secured to the he flip-top openings to the were not secured. All and staff had access to the when carts were left allways. 6 p.m. the consultant he facility policy should be stion of medications, but the rould be folded together and r system. The consultant the fentanyl patches should in the sharps containers. 19 a.m. licensed practical and used fentanyl patches were dof in the sharps container. A cas observed on the medication unsecured and one on the behind the desk with the doo and findings. All staff access the formunication board and ator. LPN-A stated the sharps kept in the back room until down to the locked storage e the facility. LPN-A stated an local picks the sharps	r e			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00589	B. WING		10/	27/2016
NAME OF I	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
BAYSHO	RE RESIDENCE & RE	FHAR CTR	I ST LOUIS AVENU .UTH, MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21610	on the Beachwalk L. On 10/27/16, at 10: sharps containers at the desk. RN-A also the sharps contained disposed of in the source of the sharps contained disposed of in the source of the sharps containers were flushing them into the sharps containers were brown biohazard storage to containers were brown the disposal commetal shed that was attached to a cable the roof of the shed stated the nurses a aides (TMA) knew a and the contents of maintenance would administrator came storage bin and who for diversion, he staright away. The key was removed and the carried by the nurse on 10/27/16 at 2:19 patches were disposite on 10/27/16, at 3:2 (DON) stated the fee	unit. 53 a.m. RN-A verified the should not be in the room led verified staff had access ers, and fentanyl patches a sharps containers. 4 p.m. RN-A stated she narmacist and the policy a be flushing fentanyl patchen. RN-A verified some nurse and some were putting the tainers. RN-A identified the poin, where the sharps bught for storage until pick apany. The storage until pick appropriate the lock, and the key was and hanging on a cable unit, just above the lock. RN-and the trained medication about the location of the key the shed, and also stated also know about it. The coutside, to the biohazard en asked about the potent atted the key would be remained to the biohazard storage orought to a locked drawer at to the drawer were to be	nd nes ses em e a up as a nder A ey tial oved bin on anyl ainer. aing	DEFICIENCY		
		ntainers. The DON verified ole to all staff, visitors, and				

Minnesota Department of Health

STATE FORM Y9ZW11 If continuation sheet 31 of 46

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00589	B. WING		10/2	27/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR	LOUIS AVENI I, MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	residents. The DON not be kept on the sbiohazards. The undated facility Storage of Medicati that have missing, i incorrect labels sha for proper labeling to the undated facility Discarding and Desnursing to destruct manner that would longer usable or avillegally diverted. SUGGESTED MET The director of nurs development and in procedures to ensurand disposed of proor designee could and procedures. The designee could the adherence to the position of the signee could the adherence to the position of the signee could the adherence to the position of the signee could the adherence to the position of the signee could the signee.	N also verified the key should storage shed for the repolicy and procedure for sions directed drug containers incomplete, improper, or all be returned to the pharmacy				
21665	A nursing home mu functional, comforta environment, allowi	O Physical Environment ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.	21665			
	This MN Requirement by:	ent is not met as evidenced				

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	FHAR CTR	OUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	Continued From pa	age 32	21665			
	review, the facility f and homelike envir	ion, interview, and document failed to maintain a safe, clean conment in 8 of 40 resident 222, 237, 248, 252, 259, 263,				
	Findings include:					
	supervisor (MS), th	with the maintenance be housekeeping director (HD) tor the following environmental				
	Room 204, the room door on the inside edge at the bottom was chipped approximately 4 inches by 2 inches causing a sharp surface. At the room entry at the bottom edge outside the door the molding was missing and the sheetrock was chipped.					
		nt legs of the commode over by on the bottom approximately				
	Room 237, the bath coating as if chippe	hroom floor tile had a white ed or rubbed off.				
	Room 248, the bath were scuffed. The bath with inserts which w	hroom and room door frames bathroom floor had small holes were filled with dirt.				
		eelchair was dirty and had fferent colors that were frayed				
	Room 259, the left several long tears.	wheelchair arm rest had				
	Room 263, the carp	pet in the center of the room				

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 33 of 46

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00589		B. WING		10/2	27/2016
	PROVIDER OR SUPPLIER	EHAB CTR	1601 ST L	ORESS, CITY, S OUIS AVENI MN 55802	STATE, ZIP CODE UE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21665	Continued From pa	•		21665			
	was stained and loose. Room 264, the bathroom smelled of urine and the floor grout in the bathroom was dark and appeared dirty.						
	The MS and the HE assistants (NA) were wheelchairs to the way Wheelchairs were a when a resident discomputer system the maintenance or any computerized requestated 10 rooms were	re to take reswheelchair walso washed charged. The nat maintains y staff can mest for repair	sident's vasher. and repaired e facility had a s a schedule for ake a s. The MS further				
	A policy was reques	sted but not p	orovided.				
	SUGGESTED MET The Director of Mai develop, review, an procedures to ensu environment. The Director of Mai educate all appropr procedures. The Director of Mai develop monitoring compliance. TIME PERIOD FOR (21) days.	ntenance or d/or revise p re a safe, cle ntenance or iate staff on ntenance or systems to e	designee could colicies and cean, homelike designee could the policies and designee could ensure ongoing				
21830	MN St. Statute 144 Residents of HC Fa			21830			
	Subd. 10. Particip notification of family		nning treatment;				
	(a) Residents shall	II have the ri	ght to participate				

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 34 of 46

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 20.23			
		00589	B. WING		10/2	7/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	FHAR CTR	OUIS AVEN	JE		
	I	DULUTH,	MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21830	in the planning of the includes the opport alternatives with incopportunity to require care conferences, a family member or oboth. In the event the present, a family member or conferences. (b) If a resident with unconscious or conferences or communicate, the fefforts as required either a family member to person the planning, unless the	neir health care. This right unity to discuss treatment and dividual caregivers, the lest and participate in formal and the right to include a other chosen representative or that the resident cannot be lember or other representative dent may be included in such who enters a facility is matose or is unable to facility shall make reasonable under paragraph (c) to notify the net as the person to contact in the resident has been lity. The facility shall allow the participate in treatment e facility knows or has reason	21830			
	to believe the resid directive to the con specified in writing member included in notifying a family member to pplanning, the facility efforts, consistent oppractice, to determine executed an advance sident's health can this paragraph, "reaction (1) examining the resident; (2) examining the resident in the possion (3) inquiring of a family member consideration with the consideration of the possion of the pos	ent has an effective advance trary or knows the resident has that they do not want a family in treatment planning. After lember but prior to allowing a varticipate in treatment y must make reasonable with reasonable medical ine if the resident has ce directive relative to the re decisions. For purposes of asonable efforts" include: e personal effects of the emedical records of the session of the facility; ny emergency contact or tacted under this section in thas executed an advance				

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION		A/SUPPLIER/CLIA ATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BUILDING:			
		00589		B. WING		10/2	7/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	EHAB CTR		OUIS AVENI MN 55802	JE .		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	directive and wheth physician to whom care; and (4) inquiring of the resident normally go whether the resident designated emerger member to participa accordance with the liable to resident for the notification of the mergency contact family member was patient's privacy rigue (c) In making reasonable facility shall attemembers or a design examining the persuand the medical records.	the resident note physician to oes for care, in thas execute y notifies a farmory contact of ate in treatments paragraph, or damages on the participal improper or the participal impro	owhom the own whom the own whom the own, who was a family who planning in the facility is not on the grounds that own who will be own who will				
	possession of the fit on notify a family memergency contact admission, the facil social service agen agency that the rest he facility has been member or designate county social service enforcement agency identifying and notified designated emerges service agency or lethat assists a facilit subdivision is not liadamages on the grather family member participation of the	ember or desi within 24 hou ity shall notify cy or local law ident has been unable to not ted emergency and sy shall assistiving a family ency contact. Ocal law enfory in implementable to the resounds that the or emergency	ignated ars after the arthe county of enforcement an admitted and otify a family cy contact. The al local law the facility in member or A county social accement agency onting this sident for a notification of ay contact or the				

6899

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	-HAB CTR	OUIS AVENI MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21830	Continued From pa		21830			
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview, and document ailed to ensure bathing ces for 1 of 3 residents (R15) es.				
	Findings include:					
	R15's Diagnosis Report dated 10/27/16, indicated R15's diagnoses included chronic obstructive pulmonary disease (COPD), diabetes with diabetic neuropathy, and chronic kidney disease.					
	10/6/16, indicated Rhad no behaviors of further indicated Rhwith bed mobility, tripersonal hygiene. The was occasionally in indicated bathing diassessment period 7/7/16, indicated Rhadhing, and it was	num Data Set (MDS) dated R15 was cognitively intact, and r rejection of cares. The MDS 5 required staff assistance ansfers, dressing and The MDS also indicated R15 continent of bladder. The MDS id not occur during the The annual MDS dated 15 required assistance with very important for R15 to tub bath, a shower, a bed or				
	required the extens bathing (including t shower chair). The guide updated on 9 the bath list for bath Schedule updated of	ed on 10/5/16, indicated R15 ive assistance of one staff for ransfer assistance to the nursing assistant (NA) care /23/16, directed staff to see a days. The Weekly Shower on 10/25/16, indicated R15 a shower on Tuesday and				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

10/27/2016

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) COMPLETE DATE			
PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETI			
	On 10/27/16, 2:30 p.m. licensed practical nurse (LPN)-A stated R15 refused the shower at times because he stayed up late and would sleep all day. R15 refused if he was sleepy. LPN-A verified R15 was scheduled for a shower on Tuesday and Saturday in the afternoon. LPN-A was unable to find documentation of R15's refusals.						

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.1. 20.22			
		00589	B. WING		10/2	7/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	FHAR CTR	LOUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	On 10/27/16, at 2:4 worked afternoons she had never had On 10/27/16, at 3:2 (DON) stated he wowas scheduled a bath twice week. If bath, the DON wou recorded, with the refused. The DON to be offered a bath why a resident refu DON would expect medical record. The sheets were derive plan was built and to over to the NA care. The facility was unaresident choices. SUGGESTED MET director of nursing develop and impler resident's choices we designee could edu DON or designee consure ongoing consumers on the consumer on the cons	on R15's unit. NA-M stated R15 refuse a shower. O p.m. the director of nursing ould expect a resident who ath twice a week, to receive a a resident did not receive a a resident did not receive a reason why the resident would then expect the resident would then expect the resident at the next day, and/or find out sed a bath and reassess. The refusals be documented in the e DON stated the NA care of from the care plan. The care the information was carried a sheets. Able to provide a policy on THOD OF CORRECTION: The (DON) or designee could ment systems to ensure were honored. The DON or ucate all appropriate staff. The could monitor this process to				
21995	Maltreatment of Vu Subd. 4a. Interna	.557 Subd. 4a Reporting - Inerable Adults Il reporting of maltreatment. all establish and enforce an	21995			
	ongoing written pro	ocedure in compliance with grules to ensure that all cases				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00589		B. WING		10/2	27/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR		OUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG		TEMENT OF DEFICI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21995	of suspected maltre facility has an interr mandated reporter requirements of this internally. However responsible for comreporting requirements. This MN Requirements of this internally. However responsible for comreporting requirements. This MN Requirements of the facility failed to immade Agency (SA) potents for 4 of 4 residents. R76) reviewed for a Findings include: The facility did not incident of mistreating agency; an incident and was submitted the SA. R130's Admission Find that included need failed and reduced mobility. Data Set (MDS) data was cognitively inta wheelchair for mobility. R130's care plan data increased risk for to physical impairm. On 10/24/16, at 3:5 physically abused be R130 stated he was another resident. R	eatment are replication and document and allegations of residents (R130 abuse. Immediately report and and and and allegations of this section and allegations of the and and document and allegations of the and allegations of the and and and and and allegations of the and	pocedure, a eporting porting mains immediate fon. as evidenced review, the to the State of mistreatment D, R30, R61, port an alleged 130 to the state of on 3/6/16, unknown) to diagnoses ersonal care terly Minimum icated R130 walker and a dicated he was om others due obility. The stomach by old staff and	21995			
	another resident. R nothing was done e						

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 40 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0589

MAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X4) MULTIPLE CONSTRUCTION A. BUILDING: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

BAYSHORE RESIDENCE & REHAB CTR 1601 ST		STREET ADDRESS, CITY, S	STATE, ZIP GODE	
		1601 ST LOUIS AVENI DULUTH, MN 55802	UE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995		21995 Doort to the hit in the on 3/6/16. Ort indicated er R130's me note further R130's Dorker (SW)-A and of the sawhen she she knew it then End he didn't 130 stated wrong. R130 and block his sa door. R130 ey felt R107 of targeted ed R107 e wasn't mad sing it. R130 ning and it e changed stated then it son. Et an alleged		DATE

6899

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____

> 00589 B. WING ___ 10/27/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BAYSHO	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) COMPLETE DATE				
21995	Continued From page 41	21995						
	R30's Admission Record identified a diagnosis of quadriplegia. R30's quarterly MDS dated 8/30/16, indicated R30 was cognitively intact, and was totally dependent upon staff for toileting.							
	R30's care plan dated 3/10/16, indicated R30 required use of a colostomy. The goal indicated R30's dignity would be maintained and the ostomy would remain patent/functional through the next review date. The care plan also indicated R30 was at risk for injury/abuse from others due to mobility deficits.							
	On 10/25/16, at 10:05 a.m., R30 stated there was a time when a nursing assistant refused to empty his colostomy bag. R30 also stated the staff person closed the door after the refusal. R30 stated he didn't have his "tool" on his hand, so he couldn't open the door handle, and his call light was out of reach. R30 stated another staff person came soon after to assist him.							
	According to the facility's investigative report, during evening cares on 9/21/16, a nursing assistant (NA) refused to assist R30 with emptying R30's ostomy bag and closed R30's bedroom door behind him as he left.							
	On 10/26/16, at 1:16 p.m. the DON stated he learned of the incident on 9/22/16, at 10:30 a.m. and reported it to the State Agency by 10:30 a.m. on 9/23/16.							
	The facility did not immediately report an alleged incident of mistreatment against R61 to the SA. An incident occurred on 9/3/16, at 2030; an incident report was submitted on 9/6/16 (time unknown).							
	R61's Admission record identified a diagnosis of							

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 42 of 46 Y9ZW11

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00589		B. WING		10/27/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RI	-HAB CTR	OUIS AVEN	JE		
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	MN 55802	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21995	Continued From pa	ge 42	21995			
	Alzheimer's disease. R61's quarterly MDS dated 7/27/16, indicated R61 had severely impaired cognition, and required limited assistance (guided maneuvering of limbs or other non-weight bearing assistance) with walking in her room, in the corridor and on the unit. The MDS also indicated R61 used a walker.					
	R61's care plan dated 8/2/16, indicated R61 has the potential to wander into other people's rooms in search of her own. Staff were directed to distract and reorient the resident as needed to safe areas. The care plan also identified R 61 was at risk for injury/abuse from others due to her diagnosis of dementia, her cognitive deficits, and her risk of wandering.					
	slammed R61's har was in his room. R8 his call light to call the replied "whatever" a 9/7/16, a progress in indicated that on 9/1 another resident's redirected, the other R61's hand. R61 st The physician was	ior/mood note indicated R53 and in his door, because she 53 was educated on pressing for assistance, at which R53 and closed his door. On note in R61's medical record 3/16, R61 wandered into com, and before R61 could be a resident closed the door on ated that her hand did hurt. updated, and orders were hand, and monitor for two				
	On 10/26/16, at 12:33 p.m. SW-A confirmed there was nothing to indicated the DON or administrator were notified at the time of the incident					
	On 10/26/16, at 1:39 p.m. the administrator stated staff thought this was an accident and not abuse. The administrator stated he reviewed notes the next day during morning meeting and					

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 43 of 46

10/27/2016

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

00589

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING ___

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) COMPLETE DATE			
21995	Continued From page 43	21995					
	didn't want it to be a question in the future, so the facility reported the incident while it was still fresh in their minds.						
	The facility did not immediately report an incident of mistreatment against R76 to the SA. On 9/16/16, in an attempt to reach for her call light, R76 fell from her wheelchair and received an abrasion to her face. The incident was not reported to the SA until 9/20/16 (time unknown). R76's Admission Record identified diagnoses that						
	included Parkinson's disease, vascular dementia, and low back pain. R76's quarterly MDS dated 9/27/16, indicated R76 had moderately impaired cognition, and required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toileting and personal hygiene. The MDS further indicated R76 did not walk during the assessment period.						
	R76's care plan dated 1/19/16, directed staff to keep the call light within reach at all times. The care plan also identified R76 was at risk for injury/abuse from others due to cognitive deficits.						
	On 10/26/16, at 12:33 p.m. SW-A confirmed R76 was found on the floor on 9/16/16, and the incident was not reported to the SA until 9/20/16.						
	On 10/26/16, at 1:39 p.m. the administrator stated he believed this incident was not reported immediately because staff did not think it needed to be reported as R76 did not sustain a major injury. The administrator also stated it should have been reported as the call light was not within reach, thus the care plan was not being followed.						
	On 10/26/16, at 1:16 p.m. the director of nursing (DON) stated if there is an incident either the						

Minnesota Department of Health STATE FORM

6899 Y9ZW11 If continuation sheet 44 of 46

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		00589	B. WING		10/2	7/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAR CTR	OUIS AVENI MN 55802	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From particles on 10/26/16, at 1:3 stated he expects to reportable incident hours. The administ the DON or SW-A, regarding abuse prostated he or SW-A determine if an everadministrator stated same way as he is exceed 24 hours. The administrator stated same way as he is exceed 24 hours. The administrator simmediately after the incident. The administrator simmediately after the incident. The administrator stated on abuse prohibition. The facility Abuse Facili	ge 44 strator are called by staff. 9 p.m. the administrator o be notified of any potential immediately, not to exceed 24 trator stated staff will call him, who are the facility's contacts ohibition. The administrator are often the staff that nt is reportable. The d the SA should be notified the notified: immediately not to he administrator added the ade as soon as is practicable. tated leadership report ney are made aware of an histrator stated if an incident of ent occurred on a Saturday rt should be made then. The d they educate staff annually	21995			
	SUGGESTED MET	HOD OF CORRECTION: r designee could develop				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00589	B. WING		10/2	7/2016
NAME OF	PROVIDER OR SUPPLIER		ORESS, CITY, S	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	-HAR("IR	OUIS AVENI MN 55802	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	policies regarding a administrator or des on these policies. T could develop a mo ongoing compliance	abuse prohibition. The signess could educate all staff he administrator or designee onitoring system to ensure	21995			

Minnesota Department of Health

STATE FORM 6899 Y9ZW11 If continuation sheet 46 of 46