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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y9ZW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00589

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

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

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

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

6. DATE OF SURVEY **01/20/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 02/072017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/19/2016
(L33)

DETERMINATION APPROVAL

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, 2017:

- 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.

MDH
Minnesota Department of Health

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 Meath

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

Minnesota Department of Health

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.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245227		1/20/2017

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 01/16/2017	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 01/16/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) TA/mm	DATE 02/07/2017	SIGNATURE OF SURVEYOR 34089	DATE 01/20/2017
REVIEWED BY 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? ☐ YES ☐ NO

Minnesota Department of Health

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 Meath

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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00589		1/20/2017

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 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 01/16/2017	ID Prefix 21610 Reg. # MN Rule 4658.1340 Subp. 1 LSC	Correction Completed 01/16/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** TA/mm	**DATE** 02/07/2017	**SIGNATURE OF SURVEYOR** 34089	**DATE** 01/20/2017
REVIEWED BY 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? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y9ZW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00589

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

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

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

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

6. DATE OF SURVEY **12/21/2016/** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
__ 1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Suan Frericks, HPR SWS 01/17/2017
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/01/2017
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/19/2016
(L33)

DETERMINATION APPROVAL

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.

Minnesota Department of Health

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

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

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;

- 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

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 Meath

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

Enclosure(s)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R 12/21/2016

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) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 12/19/16, 12/20/16, and 12/21/16, to determine compliance with Federal deficiencies issued during a recertification survey exited on 10/27/16. During this visit the following regulations were determined to be not corrected. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	{F 431}	F 431- E Corrective Action: A. Insulin pens for residents R44, R89, R33, R18, R117, R162, R10, R13, R14, R97, R100, R30, and R20, have been separated by appropriate barrier to prevent cross-contamination for each device. Each pen has opened date listed, the proper label, directions, and expiration dates. B. Humalog, Novolog, Lantus, and Novalin are now stored in separate baggies. Date of Completion: January 17, 2017 Corrective Actions as it applies to other Residents: A. All insulin pens in the med carts have been separated by appropriate barrier to prevent cross-contamination for each device. Each pen has opened date listed, the proper label, directions, and expiration dates. B. All nurses and TMA's have received education expectations on the Storage of Medication Policy. C. All nurses and TMA's have received education expectations on the Labeling of Medications.	

MA 1/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 1/16/17

'eficiency 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R 12/21/2016

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) COMPLETION DATE
{F 431}	Continued From page 1 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were labeled with directions for use and/or opened date or expiration date for 13 of 19 residents (R44, R89, R33, R18, R117, R162, R10, R13, R14, R97, R100, R30, R20) who used insulin pens. Findings include: On 12/19/16, at 10:13 a.m. on Harbor Light unit: -R44's Lantus insulin (long-acting insulin) pen was not dated with opened date or expiration date, and was not labeled with directions for use. R44's Humalog (fast-acting insulin) insulin pen was not labeled with directions for use. Assistant director of nursing (ADON) verified findings at that time.	{F 431}	D. Facility has been in communication with 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/cart audits 4x's per week for 2 weeks, then weekly audits for 4 months. B. Facility will perform 'Insulin Pen Compliance' audits weekly for four months to assure proper storage, labeling, and dating. C. Audit findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person- Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 2 On 12/19/16, at 10:23 a.m. on Morning Light unit: -R89's Novolog Flex insulin pen was in a baggie with her name on the baggie 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. -R18's Humalog 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 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. 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 Lantus. -R13's Lantus pen was not labeled with directions for use. RN-C verified the findings.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 3 On 12/21/16, at 10:12 a.m. on Harbor Light unit: - R44's Humalog insulin pen was in a baggie and was not labeled with directions for use. On 10/21/16, at 10:15 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 label and an opened date. -R97's Lantus insulin pen lacked a label. -R100's Novalin R (fast-acting insulin) lacked a label. -R18's Lantus insulin pen lacked a label and an opened date. R18's Humalog lacked a label for use. -R33's Novolog insulin pen lacked a label and an opened date. -R30's Novolog lacked a label and an opened date. -R20's Lantus lacked a label with directives for use. R20's Novolog lacked a label. Licensed practical nurse (LPN)-D verified insulin pens should be in their own baggie with labels for use and open/expiration dates on them. LPN-D stated the insulin pens should be dated. LPN-D stated she did not know when the pens were opened. The undated facility policy and procedure for Storage of Medications directed drugs to be stored in the packaging, containers or other dispensing systems in which they are received. The undated facility policy and procedure for Labeling of Medication Containers directed any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy and labels for	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 4 individual drug containers should include all necessary information including directions for use and expiration date.	{F 431}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	{F 441}	**F 441- F** Corrective Action: A. Staff caring for R128 have received education on proper handwashing/sanitizing/glove use. Corrective Action as it applies to other Residents: A. Handwashing, sanitizing, and gloving training has been provided to facility staff. Date of Completion: January 17, 2017 Recurrence will be prevented by: A. Facility Staff received education on handwashing, sanitizing and gloving. B. Facility will participate in I-CAR. An I-CAR review is scheduled for 1/31/17 at 1:30p.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 441}	Continued From page 5 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene practices were maintained during toileting cares for 1 of 3 residents (R128) observed during incontinent or toileting cares. Findings include: R128's Admission Record printed 12/20/16, indicated R128 had a diagnosis of urinary incontinence. R128's admission MDS dated 10/4/16, indicated R128 had moderate impairment for cognitive skills for daily decision-making, and required assistance of 2 staff for toilet use. R128's care plan initiated 10/7/16, indicated R128 was frequently incontinent of bowel and bladder and was at risk for urinary tract infections. R128's care plan directed staff to check for incontinence every 2 hours and rinse and dry his perineum, monitor for signs and symptoms of infection. On 12/20/16, at 10:06 a.m. NA-P brought R128 to his bathroom, put on gloves and helped to remove R128's incontinent brief as he sat on the toilet. NA-P placed the soiled incontinent brief (with a small amount of stool and urine) into the garbage, removed her gloves and left the bathroom. NA-P did not perform hand hygiene.	{F 441}	C. DON, ADON, Education Nurse and other designees will observe at least five on-the-spot demonstrations of staff handwashing/gloving procedure per week for four weeks, then once weekly audits for 4 months. D. DON, ADON, Education Nurse and other designees will perform handwashing and glove use audits 4x's per week for 2 weeks, then weekly audits for 4 months. E. Audit findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 441}	Continued From page 6 NA-P took a clean incontinent brief from a drawer in R128's room, returned to the bathroom, and put clean gloves on. NA-P cleansed R128's leg of urine with a cleansing wipe, took out clean wipes and as R128 stood, NA-P wiped his buttocks of stool with the wipes, and disposed of them into the garbage. NA-P adjusted the brief, pulled up R128's pants and helped him to the sink so he could wash his hands. NA-P removed her gloves without doing hand hygiene, pulled the wheelchair out of the room, then tied up the garbage bag, opened the room door, and left the room. NA-P then opened the door to the utility room, put the garbage bag into the garbage,and then sanitized her hands. On 12/20/16, at 10:18 a.m. NA-P stated she sanitized her hands when entering R128's room, after toileting, and after throwing away the garbage. NA-P verified she had not sanitized between glove changes, touched clean things and clothes, and should have cleaned her hands between glove changes and after removing gloves. 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 perl care, wash hands, re-glove, finish cares, remove gloves and sanitize or wash hands before leaving the room. The undated facility policy and procedure for Handwashing/Hand Hygiene directed staff to sanitize or wash hands before and after direct contact with residents, before moving from a contaminated body site to a clean body site	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	R 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 441}	Continued From page 7 during resident care, after contact with blood or bodily fluids, and after removing gloves.	{F 441}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245227 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0242	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(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 F0315	Correction	ID Prefix F0353	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TA/mm	01/04/2017	34983	12/15/2016
REVIEWED BY 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? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245227 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/15/2016 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 12/08/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 12/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	01/04/2017	12/15/2016	12/15/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/25/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

MDH
Minnesota Department of Health

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, ***you will be assessed an amount of $600.00 per day beginning on the day you receive this notice***.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00589	A. BUILDING: _____ B. WING _____	R 12/21/2016

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
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 12/21/2016. During this onsite visit it was determined that the following corrections orders: 2 - 1375, 2 - 1610, were not corrected. These uncorrected orders will remain in effect and will be reviewed at the next onsite visit. Also uncorrected orders will be reviewed for possible	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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{2 000}	Continued From page 1 penalty assessments.	{2 000}	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 which 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. 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.	
{21375}	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	{21375}		

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{21375}	Continued From page 2 review, the facility failed to ensure proper hand hygiene practices were maintained during toileting cares for 1 of 3 residents (R128) observed during incontinent or toileting cares. Findings include: R128's Admission Record printed 12/20/16, indicated R128 had a diagnosis of urinary incontinence. R128's admission MDS dated 10/4/16, indicated R128 had moderate impairment for cognitive skills for daily decision-making, and required assistance of 2 staff for toilet use. R128's care plan initiated 10/7/16, indicated R128 was frequently incontinent of bowel and bladder and was at risk for urinary tract infections. R128's care plan directed staff to check for incontinence every 2 hours and rinse and dry his perineum, monitor for signs and symptoms of infection. On 12/20/16, at 10:06 a.m. NA-P brought R128 to his bathroom, put on gloves and helped to remove R128's incontinent brief as he sat on the toilet. NA-P placed the soiled incontinent brief (with a small amount of stool and urine) into the garbage, removed her gloves and left the bathroom. NA-P did not perform hand hygiene. NA-P took a clean incontinent brief from a drawer in R128's room, returned to the bathroom, and put clean gloves on. NA-P cleansed R128's leg of urine with a cleansing wipe, took out clean wipes and as R128 stood, NA-P wiped his buttocks of stool with the wipes, and disposed of them into the garbage. NA-P adjusted the brief, pulled up R128's pants and helped him to the sink so he could wash his hands. NA-P removed her gloves	{21375}		

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{21375}	Continued From page 3 without doing hand hygiene, pulled the wheelchair out of the room, then tied up the garbage bag, opened the room door, and left the room. NA-P then opened the door to the utility room, put the garbage bag into the garbage,and then sanitized her hands. On 12/20/16, at 10:18 a.m. NA-P stated she sanitized her hands when entering R128's room, after toileting, and after throwing away the garbage. NA-P verified she had not sanitized between glove changes, touched clean things and clothes, and should have cleaned her hands between glove changes and after removing gloves. 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. The undated facility policy and procedure for Handwashing/Hand Hygiene directed staff to sanitize or wash hands before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, and after removing gloves.	{21375}		
{21610}	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit	{21610}		

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{21610}	Continued From page 4 only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were labeled with directions for use and/or opened date or expiration date for 13 of 19 residents (R44, R89, R33, R18, R117, R162, R10, R13, R14, R97, R100, R30, R20) who used insulin pens. Findings include: On 12/19/16, at 10:13 a.m. on Harbor Light unit: -R44's Lantus insulin (long-acting insulin) pen was not dated with opened date or expiration date, and was not labeled with directions for use. R44's Humalog (fast-acting insulin) insulin pen was not labeled with directions for use. Assistant director of nursing (ADON) verified findings at that time. On 12/19/16, at 10:23 a.m. on Morning Light unit: -R89's Novolog Flex insulin pen was in a baggie with her name on the baggie 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. -R18's Humalog 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	{21610}		

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{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. 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 Lantus. -R13's Lantus pen was not labeled with directions for use. RN-C verified the findings. On 12/21/16, at 10:12 a.m. on Harbor Light unit: - R44's Humalog insulin pen was in a baggie and was not labeled with directions for use. On 10/21/16, at 10:15 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 label and an opened date. -R97's Lantus insulin pen lacked a label. -R100's Novalin R (fast-acting insulin) lacked a label. -R18's Lantus insulin pen lacked a label and an opened date. R18's Humalog lacked a label for use. -R33's Novolog insulin pen lacked a label and an	{21610}		

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{21610}	Continued From page 6 opened date. -R30's Novolog lacked a label and an opened date. -R20's Lantus lacked a label with directives for use. R20's Novolog lacked a label. Licensed practical nurse (LPN)-D verified insulin pens should be in their own baggie with labels for use and open/expiration dates on them. LPN-D stated the insulin pens should be dated. LPN-D stated she did not know when the pens were opened. The undated facility policy and procedure for Storage of Medications directed drugs to be stored in the packaging, containers or other dispensing systems in which they are received. The undated facility policy and procedure for Labeling of Medication Containers directed any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy and labels for individual drug containers should include all necessary information including directions for use and expiration date.	{21610}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Y9ZW

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

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

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

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

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

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

6. DATE OF SURVEY **10/27/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **139** (L18)

13.Total Certified Beds **139** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program
Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Kathie Killoran, HFE NEII — 12/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 12/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

RECEIVED
NOV 28 2016
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	10/27/2016

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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility plan of correction (POC) will serve as you allegation of compliance upon the department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	**F 225- D** Corrective Action: A. Facility visited with R130, R30, R61, and R76. The safety of all four residents has been assured. Corrective Actions as it applies to other Residents: A. The Abuse Prevention Plan was reviewed. Facility staff members were re-educated about the Abuse Prevention Plan and the definition of Immediate Reporting to Administrator/State Agency (SA). The education occurred at the All Staff Meetings completed the week of 11-28-16.	

11/30/16 JA

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

Executive Director | 11/23/16

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

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State Agency (SA) potential allegations of mistreatment for 4 of 4 residents residents (R130, R30, R61, R76) reviewed for abuse. Findings include: The facility did not immediately report an alleged incident of mistreatment against R130 to the state agency; an incident report occurred on 3/6/16, and was submitted on 3/7/16 (time unknown) to the SA. R130's Admission Record identified diagnoses that included need for assist with personal care and reduced mobility. R130's quarterly Minimum Data Set (MDS) dated 9/29/16, indicated R130 was cognitively intact, and used a walker and a wheelchair for mobility devices. R130's care plan dated 1/25/16, indicated he was at increased risk for injury/abuse from others due	F 225	Date of Completion: December 8, 2016 Recurrence will be prevented by: A. Facility Staff received education related to the Abuse Prevention Plan, the definition of 'immediate reporting' the initial report to Administrator/SA at the All Staff Meetings completed the week of 11-28-16. B. Facility will perform audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Administrator or Designee	

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F 225	Continued From page 2 to physical impairments and low mobility. On 10/24/16, at 3:52 p.m. R130 stated he was physically abused by another resident (R107). R130 stated he was punched in the stomach by another resident. R130 stated he told staff and nothing was done except putting a mesh stop sign across his room door. According to the facility's incident report to the State Agency (SA), R130 was lightly hit in the stomach by another resident, R107, on 3/6/16. Progress notes with the incident report indicated R107 made multiple attempts to enter R130's room that shift, and at one point in time approached tightening his fists. The note further indicated R107 was hovering around R130's room causing R130 some concern. On 10/26/16, at 12:33 p.m. social worker (SW)-A stated she wasn't immediately notified of the incident involving R130. SW-A states when she got the information and reviewed it, she knew it was reportable, and the incident was then reported to the SA. On 10/27/16, at 8:54 a.m. R130 stated he didn't like how the incident was handled. R130 stated he felt as if he was doing something wrong. R130 stated R107 would stand in the hall and block his progress and R107 would stare at his door. R130 stated staff would close his door if they felt R107 was targeting him. R130 stated R107 targeted him after the incident too. R130 stated R107 didn't know what he was doing, so he wasn't mad at him, but at the staff for not addressing it. R130 stated change was really slow in coming and it wasn't until R107's medications were changed that he stopped targeting him. R130 stated then it	F 225		

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F 225	Continued From page 3 felt like a R107 was a whole new person. The facility did not immediately report an alleged incident of mistreatment (neglect) against R30 to the SA. An incident occurred the evening of 9/21/16; an incident report was submitted on 9/23/16 (time unknown). 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.	F 225		

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F 225	Continued From page 4 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 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. On 9/3/16, a behavior/mood note indicated R53 slammed R61's hand in his door, because she was in his room. R53 was educated on pressing his call light to call for assistance, at which R53 replied "whatever" and closed his door. On 9/7/16, a progress note in R61's medical record indicated that on 9/3/16, R61 wandered into another resident's room, and before R61 could be redirected, the other resident closed the door on R61's hand. R61 stated that her hand did hurt. The physician was updated, and orders were received to ice the hand, and monitor for two days.	F 225		

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F 225	Continued From page 5 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 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.	F 225		

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F 225	Continued From page 6 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 DON or the administrator are called by staff. On 10/26/16, at 1:39 p.m. the administrator stated he expects to be notified of any potential reportable incident immediately, not to exceed 24 hours. The administrator stated staff will call him, the DON or SW-A, who are the facility's contacts regarding abuse prohibition. The administrator stated he or SW-A are often the staff that determine if an event is reportable. The administrator stated the SA should be notified the same way as he is notified: immediately not to exceed 24 hours. The administrator added the report should be made as soon as is practicable. The administrator stated leadership report immediately after they are made aware of an incident. The administrator stated if an incident of potential mistreatment occurred on a Saturday afternoon, the report should be made then. The administrator stated they educate staff annually on abuse prohibition. The facility Abuse Prohibition Plan dated 5/20/16, directed staff to report suspected maltreatment immediately through either the internal or external report systems. The policy directed staff to begin an internal investigation immediately. The policy further directed staff report suspected abuse	F 225		

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F 225	Continued From page 7 internally to the administrator, social service director or DON, and if these individuals are not in the building, staff are to report to the nursing supervisor, nurse manager or team leader at the time of suspicion. The policy directed reporting takes place but lacked specification of the timeframe for that reporting. The policy indicated internal investigation of suspect abuse begins immediately.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement an abuse prohibition policy which required immediate notification to the State Agency (SA) for allegations of mistreatment prior to conducting investigations for 4 of 4 residents residents (R130, R30, R61, R76) reviewed for abuse. Findings include: The facility Abuse Prohibition Plan dated 5/20/16, directed staff to report suspected maltreatment immediately through either the internal or external report systems. The policy directed staff to begin an internal investigation immediately. The policy further directed staff report suspected abuse internally to the administrator, social service	F 226	**F 226- D** Corrective Action: A. R130, R30, R61, and R76. The safety of all residents has been assured. Corrective Actions as it applies to other Residents: A. The Abuse Prevention Plan was reviewed and revised. All Facility staff were re-educated about the Abuse Prevention Plan, specifically identifying abuse and the definition of 'immediate reporting' to Administrator/SA. The education occurred at the All Staff Meetings completed the week of 11-28-16. Date of Completion: December 8, 2016 Recurrence will be prevented by: A. Facility Staff received education related to the Abuse Prevention Plan, how to identify abuse, and the definition of 'immediate reporting' to the Administrator/SA at the All Staff Meetings completed the week of 11-28-16.	

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F 226	Continued From page 8 director or DON, and if these individuals are not in the building, staff are to report to the nursing supervisor, nurse manager or team leader at the time of suspicion. The policy directed reporting takes place but lacked specification of the timeframe for that reporting. The policy indicated internal investigation of suspect abuse begins immediately. The facility did not immediately report an alleged incident of mistreatment against R130 to the state agency; an incident report occurred on 3/6/16, and was submitted on 3/7/16 (time unknown) to the SA. R130's Admission Record identified diagnoses that included need for assist with personal care and reduced mobility. R130's quarterly Minimum Data Set (MDS) dated 9/29/16, indicated R130 was cognitively intact, and used a walker and a wheelchair for mobility devices. R130's care plan dated 1/25/16, indicated he was at increased risk for injury/abuse from others due to physical impairments and low mobility. On 10/24/16, at 3:52 p.m. R130 stated he was physically abused by another resident (R107). R130 stated he was punched in the stomach by another resident. R130 stated he told staff and nothing was done except putting a mesh stop sign across his room door. According to the facility's incident report to the SA, R130 was lightly hit in the stomach by another resident, R107, on 3/6/16. Progress notes with the incident report indicated R107 made multiple attempts to enter R130's room that shift, and at one point in time approached	F 226	B. Facility will perform audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Administrator	

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F 226	Continued From page 9 tightening his fists. The note further indicated R107 was hovering around R130's room causing R130 some concern. On 10/26/16, at 12:33 p.m. social worker (SW)-A stated she wasn't immediately notified of the incident involving R130. SW-A states when she got the information and reviewed it, she knew it was reportable, and the incident was then reported to the SA. On 10/27/16, at 8:54 a.m. R130 stated he didn't like how the incident was handled. R130 stated he felt as if he was doing something wrong. R130 stated R107 would stand in the hall and block his progress and R107 would stare at his door. R130 stated staff would close his door if they felt R107 was targeting him. R130 stated R107 targeted him after the incident too. R130 stated R107 didn't know what he was doing, so he wasn't mad at him, but at the staff for not addressing it. R130 stated change was really slow in coming and it wasn't until R107's medications were changed that he stopped targeting him. R130 stated then it felt like a R107 was a whole new person. The facility did not immediately report an alleged incident of mistreatment (neglect) against R30 to the SA. An incident occurred the evening of 9/21/16; an incident report was submitted on 9/23/16 (time unknown). 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	F 226		

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F 226	Continued From page 10 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 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	F 226		

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	245227	A. BUILDING _____ B. WING _____	10/27/2016

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F 226	Continued From page 11 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. On 9/3/16, a behavior/mood note indicated R53 slammed R61's hand in his door, because she was in his room. R53 was educated on pressing his call light to call for assistance, at which R53 replied "whatever" and closed his door. On 9/7/16, a progress note in R61's medical record indicated that on 9/3/16, R61 wandered into another resident's room, and before R61 could be redirected, the other resident closed the door on R61's hand. R61 stated that her hand did hurt. The physician was updated, and orders were received to ice the hand, and monitor for two days. 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 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	F 226		

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F 226	Continued From page 12 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 12:33 p.m. social worker (SW)-A stated after ensuring a resident's safety a staff person reports to the team leader, the social worker, director of nursing (DON) or administrator. If it is off hours, they would tell the team lead who would contact the DON or	F 226		

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F 226	Continued From page 13 administrator. SW-A stated if an incident is reportable, the DON would be called. If not, the clinical group (morning meeting) would discuss during business hours. SW-A stated she doesn't record the time she is notified of incidents, and the nurses document if the DON is notified. SW-A does not think the specific time of notification is documented. SW-A stated that the both the administrator and the SA should be notified immediately, or "As soon as we determine it is reportable." SW-A stated the first step is to ensure resident safety, and then begin the investigation and make reports. SW-A stated sometimes they don't realize an incident is reportable until the investigation starts, and this often happens during morning meetings or when SW-A learns of the incident. On 10/26/16, at 1:16 p.m. the director of nursing (DON) stated if there is an incident either the DON or the administrator are called by staff. On 10/26/16, at 1:39 p.m. the administrator stated he expects to be notified of any potential reportable incident immediately, not to exceed 24 hours. The administrator stated staff will call him, the DON or SW-A, who are the facility's contacts regarding abuse prohibition. The administrator stated he or SW-A are often the staff that determine if an event is reportable. The administrator stated the SA should be notified the same way as he is notified: immediately not to exceed 24 hours. The administrator added the report should be made as soon as is practicable. The administrator stated leadership report immediately after they are made aware of an incident. The administrator stated if an incident of potential mistreatment occurred on a Saturday afternoon, the report should be made then. The	F 226		

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F 226	Continued From page 14 administrator stated they educate staff annually on abuse prohibition.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bathing frequency preferences for 1 of 3 residents (R15) reviewed for choices. 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. The quarterly Minimum Data Set (MDS) dated 10/6/16, indicated R15 was cognitively intact, and had no behaviors or rejection of cares. The MDS further indicated R15 required staff assistance with bed mobility, transfers, dressing and personal hygiene. The MDS also indicated R15 was occasionally incontinent of bladder. The MDS indicated bathing did not occur during the assessment period. The annual MDS dated 7/7/16, indicated R15 required assistance with	F 242	**F 242-D** Corrective Action: A. R15 will be offered showers on planned days as he initially requested. If Resident refuses it will be documented on the shower worksheet with a reason for refusal. Additional offer for shower will offered and if refused it will be documented on the shower sheet. The shower worksheet will be audited the following day and followed to ensure the documentation is completed. Corrective Actions as it applies to other Residents: A. Facility will review all residents to assure bathing needs and preferences are being met. Date of Completion: December 8, 2016 Recurrence will be prevented by: A. Facility staff received education on bathing at the All Staff Meetings completed the week of 11-28-16.	

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F 242	Continued From page 15 bathing, and it was very important for R15 to choose between a tub bath, a shower, a bed or sponge bath. The care plan revised on 10/5/16, indicated R15 required the extensive assistance of one staff for bathing (including transfer assistance to the shower chair). The nursing assistant (NA) care guide updated on 9/23/16, directed staff to see the bath list for bath days. The Weekly Shower Schedule updated on 10/25/16, indicated R15 was scheduled for a shower on Tuesday and Saturday on the afternoon shift. The facility's Shower Day Worksheets/Body Sheet Update forms from 9/3/16, through 10/18/16, indicated of 14 opportunities for a shower, R15 had only received 3 showers. R15 did refuse a shower on 9/24/16, and on 10/15/16 the worksheet indicated staff was unable to do the shower because there was not enough staff available, and they were trying to train new staff. During observation from 10/25/16, at 8:57 a.m. through 10/27/16, at 2:00 p.m. R15's hair appeared messy and slightly greasy. On 10/25/16, at 8:57 a.m. R15 stated it had been over a month since he had received a shower. R15 stated staff tell him there was no time to do his shower. R15 further stated he would like a shower a couple of times a week. R15 stated his shower day was Saturday, and he had requested more frequent showers. The facility added a shower on Tuesday, R15 felt he did not get a shower on any day. R15 stated, "If I don't wash my hair every day it sticks up all over the place." On 10/27/16, at 2:20 p.m. trained medication	F 242	B. Facility will perform audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

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F 242	Continued From page 16 administrator (TMA)-C stated the staff was unable to get the afternoon baths done as there were only two nursing assistants (NA) on R15's unit, with a float NA between two units. 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. On 10/27/16, at 2:40 p.m. NA-M stated she worked afternoons on R15's unit. NA-M stated she had never had R15 refuse a shower. On 10/27/16, at 3:20 p.m. the director of nursing (DON) stated he would expect a resident who was scheduled a bath twice a week, to receive a bath twice week. If a resident did not receive a bath, the DON would expect the refusal to be recorded, with the reason why the resident refused. The DON would then expect the resident to be offered a bath the next day, and/or find out why a resident refused a bath and reassess. The DON would expect refusals be documented in the medical record. The DON stated the NA care sheets were derived from the care plan. The care plan was built and the information was carried over to the NA care sheets. The facility was unable to provide a policy on choices.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

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F 282	Continued From page 17 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate bathing preferences as directed by the care plan for 1 of 3 residents (R15) reviewed for bathing choices. In addition, the facility failed to ensure the care plan for toilet use was followed for 1 of 3 residents (R128) reviewed for incontinence. 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. The quarterly Minimum Data Set (MDS) dated 10/6/16, indicated R15 was cognitively intact, and had no behaviors or rejection of cares. The MDS further indicated R15 required staff assistance with bed mobility, transfers, dressing and personal hygiene. The MDS also indicated R15 was occasionally incontinent of bladder. The MDS indicated bathing did not occur during the assessment period. The annual MDS dated 7/7/16, indicated R15 required assistance with bathing, and it was very important for R15 to choose between a tub bath, a shower, a bed or sponge bath. The care plan revised on 10/5/16, indicated R15 required the extensive assistance of one staff for bathing (including transfer assistance to the	F 282	**F 282-D** Corrective Action: A. R15 will be offered showers as Plan of Care indicates with the qualified staff to perform the task. If Resident refuses, it will be documented on the shower worksheet with a reason for refusal. Additional offer for shower will offered and if refused it will be documented on the shower sheet. B. R128 will be toileted as indicated per Plan of Care. Staff education regarding following the Plan of Care and communication between staff/departments to ensure toileting schedule is met per Plan of Care. Corrective Actions as it applies to other Residents: A. The Care Plan policy has been reviewed and revised. B. The Bathing Care policy has been reviewed and revised. C. The Call Light policy was reviewed and revised. D. All Facility staff members were educated on the Care Plan, Bathing Care and Call Light Policy at the All Staff meetings completed the week of 11-28-16.	

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F 282	Continued From page 18 shower chair). The nursing assistant (NA) care guide updated on 9/23/16, directed staff to see the bath list for bath days. The Weekly Shower Schedule updated on 10/25/16, indicated R15 was scheduled for a shower on Tuesday and Saturday on the afternoon shift. The facility's Shower Day Worksheets/Body Sheet Update forms from 9/3/16, through 10/18/16, indicated of 14 opportunities for a shower, R15 had only received 3 showers. R15 did refuse a shower on 9/24/16, and on 10/15/16 the worksheet indicated staff was unable to do the shower because there was not enough staff available, and they were trying to train new staff. During observation from 10/25/16, at 8:57 a.m. through 10/27/16, at 2:00 p.m. R15's hair appeared messy and slightly greasy. On 10/25/16, at 8:57 a.m. R15 stated it had been over a month since he had received a shower. R15 stated staff tell him there was no time to do his shower. R15 further stated he would like a shower a couple of times a week. R15 stated his shower day was Saturday, and he had requested more frequent showers. The facility added a shower on Tuesday, R15 felt he did not get a shower on any day. R15 stated, "If I don't wash my hair every day it sticks up all over the place." On 10/27/16, at 2:20 p.m. trained medication administrator (TMA)-C stated the staff was unable to get the afternoon baths done as there were only two nursing assistants (NA) on R15's unit, with a float NA between two units. On 10/27/16, 2:30 p.m. licensed practical nurse (LPN)-A stated R15 refused the shower at times	F 282	Date of Completion: December 8, 2016 Recurrence will be prevented by: A. All Facility staff members were educated on the Care Plan, Bathing Care and Call Light Policy at the All Staff meetings completed the week of 11-28-16. B. Facility will perform audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

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F 282	Continued From page 19 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. On 10/27/16, at 2:40 p.m. NA-M stated she worked afternoons on R15's unit. NA-M stated she had never had R15 refuse a shower. On 10/26/16, at 2:40 p.m. the director of nursing (DON) verified the care plan should be followed. A policy on following the care plan was requested but not provided. R128's Admission Record printed 10/26/16, identified diagnoses that included dementia, urinary incontinence, and diverticulosis. R128's admission Minimum Data Set (MDS) dated 10/7/16, indicated R128 had moderate impairment of cognitive skills for daily decision-making. R128 required total assistance with transfers with two staff assist and extensive assist of 2 staff for toilet use. R128's MDS indicated he was always incontinent of urine and frequently incontinent of bowel. 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	F 282		

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F 282	Continued From page 20 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 Bladder Program Screener, indicated R128 was always incontinent of bladder and required extensive assistance for toilet use. The Bowel and Bladder screener indicated R128 was confused and needed prompting. On 10/26/16, at 7:41 a.m. continuous observations of R128 were initiated when R128 was brought from therapy in a wheelchair, to the unit common area to watch television. At 7:56 a.m. R128 was brought to the dining room for breakfast. At 8:30 a.m. R128 was brought from the dining room to the common area and set in front of the TV. At 8:50 a.m. R128 was brought to physical therapy. Continuous observations continued through R128's physical therapy session. At 9:11 a.m. certified occupational therapy aide (COTA), who had brought R128 to the common area on the unit before breakfast, as noted, stated she had worked with R128 for 70 minutes earlier and stated she gets at the facility at 6 a.m. and started working with him on upper body cares. The COTA verified she had not worked with R128 on toileting. At 9:52 a.m. R128 continued to work in physical therapy and a slight incontinence odor was detected. At 10:06 a.m. COTA stated staff toileted R128 when they got	F 282		

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F 282	Continued From page 21 him up prior to therapy. At 10:07 a.m. the physical therapist took R128 down the hall in his wheelchair. At 10:10 a.m. physical therapist set R128's wheelchair in the common area in front of the TV and left the unit. Staff were not informed R128 had returned from therapy. At 10:12 a.m. nursing assistant (NA)-B brought R128 to his bathroom to use the toilet, which was 2 1/2 hours since initiation of continuous observations and approximately 3 hours and 40 minutes since resident was changed when he was gotten up for therapy the first time. R128's incontinent brief was removed in the bathroom and smelled strongly of urine and also had bowel movement (BM) in the brief. NA-B threw the brief into the garbage. NA-B verified the brief was soiled with urine and BM. NA-B verified R128's incontinent brief had been changed before therapy the first time, and she had not toileted R128 before therapy took him to therapy again. NA-B stated she usually checks him every 2 hours. On 10/26/16, at 2:40 p.m. the director of nursing (DON) verified the care plan should be followed.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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F 315	Continued From page 22 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure toileting assistance was provided for 1 of 3 residents (R128) reviewed for incontinence. Findings include: R128's Admission Record printed 10/26/16, identified diagnoses that included dementia, urinary incontinence, and diverticulosis. R128's admission Minimum Data Set (MDS) dated 10/7/16, indicated R128 had moderate impairment of cognitive skills for daily decision-making. R128 required total assistance with transfers with two staff assist and extensive assist of 2 staff for toilet use. R128's MDS indicated he was always incontinent of urine and frequently incontinent of bowel. 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	F 315	**F315-D** Corrective Action: A. R128 will be toileted as indicated per Plan of Care. B. Staff education regarding following the Plan of Care and communication between staff/departments to ensure toileting schedule is met per Plan of Care. Corrective Actions as it applies to other Residents: A. Facility will follow toileting plan of care for all residents. B. Staff education regarding following the Plan of Care and communication between staff/departments to ensure toileting schedule is met per Plan of Care. Date of Completion: December 8, 2016 Recurrence will be prevented by: A. All Facility staff members were educated on following the plan of care and CNA care sheets at the All Staff Meetings completed the week of 11-28-16.	

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F 315	Continued From page 23 with the stand-aid lift. R128's Bowel and Bladder Program Screener, indicated R128 was always incontinent of bladder and required extensive assistance for toilet use. The Bowel and Bladder screener indicated R128 was confused and needed prompting. On 10/26/16, at 7:41 a.m. continuous observations of R128 were initiated when R128 was brought from therapy in a wheelchair, to the unit common area to watch television. At 7:56 a.m. R128 was brought to the dining room for breakfast. At 8:30 a.m. R128 was brought from the dining room to the common area and set in front of the TV. At 8:50 a.m. R128 was brought to physical therapy. Continuous observations continued through R128's physical therapy session. At 9:11 a.m. certified occupational therapy aide (COTA), who had brought R128 to the common area on the unit before breakfast, as noted, stated she had worked with R128 for 70 minutes earlier and stated she gets at the facility at 6 a.m. and started working with him on upper body cares. The COTA verified she had not worked with R128 on toileting. At 9:52 a.m. R128 continued to work in physical therapy and a slight incontinence odor was detected. At 10:06 a.m. COTA stated staff toileted R128 when they got him up prior to therapy. At 10:07 a.m. the physical therapist took R128 down the hall in his wheelchair. At 10:10 a.m. physical therapist set R128's wheelchair in the common area in front of the TV and left the unit. Staff were not informed R128 had returned from therapy. At 10:12 a.m. nursing assistant (NA)-B brought R128 to his bathroom to use the toilet, which was 2 1/2 hours since initiation of continuous	F 315	B. Facility will perform compliance audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Director of Nursing	

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F 315	Continued From page 24 observations and approximately 3 hours and 40 minutes since resident was changed when he was gotten up for therapy the first time. R128's incontinent brief was removed in the bathroom and smelled strongly of urine and also had bowel movement (BM) in the brief. NA-B threw the brief into the garbage. NA-B verified the brief was soiled with urine and BM. NA-B verified R128's incontinent brief had been changed before therapy the first time, and she had not toileted R128 before therapy took him to therapy again. NA-B stated she usually checks him every 2 hours. On 10/26/16, at 2:40 p.m. the director of nursing (DON) stated R128 should be offered toilet use every 2 hours and verified the care plan should be followed. A policy and procedure for following the care plan for toilet use was not provided.	F 315		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353		

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F 353	Continued From page 25 section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate nursing staff was provided for all 108 residents who resided in the facility. Findings include: See F242 Choices - as the facility failed to provide adequate staffing to accommodate bathing preferences for 1 of 3 residents (R15) reviewed for choices. See F315 Urinary Incontinence - as the facility failed to provide consistent staff assistance with toileting for 1 of 3 residents (R128) observed for urinary incontinence. RESIDENT CONCERNS WITH THE LACK OF ADEQUATE STAFFING: R155's quarterly Minimum Data Set (MDS) dated 8/3/16, indicated R155 was cognitively intact, was totality dependent on staff for assistance with transferring and toileting. On 10/25/16, at 9:50 a.m. R155 stated that she had waited for over an hour for a staff member to answer her call light. R155 stated she started to scream out, and then the staff would finally come. In addition, R155	F 353	**F353-F** Corrective Action: A. R15 will be offered showers per choice with Plan of Care reflecting Resident choice. R128 will be toileted as Plan of Care indicates. R155 has discharged. Call light time monitored and answered timely. R29 Nursing activity will be audited to ensure that resident does not wait an excessive amount of time for oxygen placement at bedtime and staff education regarding call light response/intervention. B. Staffing levels for RN's, LPN's, TMA's, and CNA's, will be reviewed daily by the Director of Nursing and/or Designee. C. Call Light expectations are reviewed with all facility staff. Call Light audit form developed. D. Bathing preferences were reviewed with all residents to meet their needs. E. Water Pass Policy reviewed and implemented.	

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F 353	Continued From page 26 stated the staff seemed to be rushed when they assisted her with cares and that just didn't feel right. R29's quarterly MDS dated 9/27/16, indicated R29 was cognitively intact and used oxygen therapy. On 10/27/16, at 10:22 a.m. R29 stated there was not enough nursing assistants on the night shift and at times there was only one nurse on who covered both floors at the facility. R29 stated the evening prior he had put his call light on around 12:30 a.m. as R29 required assistance to place his oxygen on for the night. R29 stated the nurse arrived at 2:00 a.m. (an hour and a half later) and placed his oxygen on him. R29 stated he didn't want to fall asleep until the oxygen had been placed as he needed the supplemental oxygen at night when he slept. R29 stated at times the nursing assistants would come in and turn the call light off and say they would be right back, and then they didn't come back. R29 stated he didn't like when the staff turned the call light off before they addressed his needs. FAMILY CONCERNS WITH LACK OF ADEQUATE STAFFING: When interviewed on 10/27/16, at 11:00 a.m. family member (FM)-A stated his wife was totally dependent on staff for cares. FM-A stated on 10/25/16, during the evening shift when he was visiting his wife, she had been incontinent of bowel and a nursing assistant told FM-A that they needed to get some help to clean her up. FM-A stated the nursing assistant wasn't able to find anyone to help so his wife sat in BM for two hours before the nursing assistants returned to clean her up. FM-A stated at times he needed to help his wife with her cares because there wasn't	F 353	Corrective Actions as it applies to other Residents: A. Facility has reviewed staffing levels to ensure facility has sufficient staffing levels to meet resident needs and preferences. This is done through daily evaluation of resident census and acuity levels by Director of Nursing and/or Designee. Date of Completion: December 8, 2016 Recurrence will be prevented by: A. All Facility staff members were educated on the call light expectation, water pass policy, bathing compliance sheets, and incontinence cares at the All Staff Meetings completed the week of 11-28-16. B. Facility will perform audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Administrator and HR	

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enough staff working. FM-A stated, "It would be nice if I didn't have to worry about her all the time." FM-A stated he felt frustrated and it broke his heart that she wasn't receiving the care she needed or deserved. FM-A stated he routinely came the facility to visit his wife twice a day.

STAFF CONCERNS:

On 10/25/16, at 10:58 a.m. nursing assistant (NA)-A, who also worked as a trained medication aide (TMA), stated she appreciated when the surveyors were at the facility as they seemed to be fully staffed. NA-A stated the nursing assistants had a hard time getting residents toileted and repositioned on time. NA-A stated when she had worked as a TMA, she tried to help the nursing assistants out when she could, however, then she was late on administering the resident's medications.

On 10/26/16, at 7:12 a.m. NA-E stated the facility had been short staff lately. NA-E stated she worked a lot of extra shifts because they were short staffed.

On 10/26/16, at 7:15 a.m. while conducting a dressing change on R18 licensed practical nurse (LPN)-B stated, she continued to work at the facility because they needed her. LPN-B stated the residents didn't always get their basic needs met like being offered fresh water and turned when they should be turned. LPN-B stated she felt that was why the facility had residents that developed pressure ulcers and had become septic.

On 10/26/16, at 9:11 a.m. NA-F stated at times she was unable to get her work completed even

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F 353	Continued From page 28 though the NA's tried very hard. NA-F confirmed during survey time the facility seemed to schedule more staff. On 10/26/16, at 10:12 a.m. NA-B stated staffing was hard. NA-B was the only person on the locked dementia unit with eight residents. NA-B stated she called for help from another unit when she needed to transfer a resident. On 10/26/16, at 11:34 a.m. NA-G stated things needed to be more organized at the facility. NA-G stated she worked full time and every two week period she was mandated to stay and work an extended shift. NA-G stated most of the time she was not able to get her work done. NA-G stated residents did not get repositioned on time or changed when they should. In addition, NA-G stated she didn't get her charting completed. NA-G stated the residents that could not speak up for themselves may not get the care they needed, because they were unable to remind the staff when they needed something. NA-G stated they no longer had a bath aide, so the nursing assistants also had to do so many baths a day besides completing their other duties. On 10/2716, at 8:23 a.m. LPN-C stated the facility was routinely short staffed. LPN-C stated she was able to complete her work because she stayed beyond her scheduled time and that was when she charted. On 10/27/16, at 9:20 a.m. NA-H confirmed she was asked to stay late either a partial or full shift ever shift she worked. NA-H stated she was mandated to stay once every two week scheduling period. NA-H stated at times there was more than one staff member who was	F 353		

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F 353	Continued From page 29 mandated to stay for the same shift. NA-H stated one weekend five staff members from the day shift were mandated to stay for the evening shift. NA-H stated there was not enough staff members to get the work completed. NA-H stated things got missed or delayed like brushing residents teeth, getting residents turned or repositioned on time, and checking and changing residents who were incontinent. NA-H stated sometimes it took her until noon to complete morning cares. NA-H stated normally she was assigned about 10 residents, however since most of the residents required two staff members, the nursing assistants just tried to work as a team. On 10/27/16, at 9:31 a.m. NA-I stated she had been mandated to stay over on her third day of orientation. NA-I stated she felt there were not enough staff to care for the residents. NA-I stated there were only two nursing assistants for 36 residents on the day shift, with only five of the residents who were fairly independent. NA-I stated she had seen staff hurt themselves because they had lifted residents by themselves and should have had two staff members assisting with the transfer. NA-I stated she was aware of residents who were not turned, repositioned, or toileted timely due to not having enough staff available. On 10/27/16, at 10:24 a.m. NA-J, who also works as a TMA, stated when she worked as a TMA she was always pulled away to assist the nursing assistants. NA-J stated when she worked as a TMA, she would have 34 residents which she was assigned and responsible for passing their medications, providing treatments, monitoring residents' blood sugars, and administering insulin. NA-J stated there had been times when	F 353		

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one nurse was assigned 51 residents to pass medications on. NA-J stated resident cares do not get done. NA-J stated she was aware of residents who were not able to speak for themselves and who required two staff to assist them with transfers, had sat up in their wheelchairs in the common area from 7:00 a.m. until 1:00 p.m. without being repositioned or changed. NA-J stated residents are not getting their baths, especially on the second floor units where there are only two nursing assistants scheduled for 34-36 residents. NA-J stated the facility was always running short of staff. NA-J stated two weeks ago they only had one nursing assistant for 24 residents, so she called someone in, and she worked as a nursing assistant and the other staff member took on NA-J's duties to pass medications.

On 10/27/16, at 10:32 a.m. NA-H stated the residents who cannot speak up for themselves or put on their call light had not received the care they needed because there wasn't enough staff to provide the care.

On 10/27/16, at 1:18 p.m. interview conducted with director of nursing (DON), the scheduler and human resource director (HRD). HRD stated staffing was one of biggest challenges the facility had. DON stated they had asked at the resident council meetings if the residents had any concerns with timeliness of call lights being answered. DON stated this had not been brought up as an area of concern by those residents who attended the resident council. DON confirmed the facility had not conducted any type of call light response time audit. However, the facility was actively advertising their open positions. DON confirmed the facility was not using any agency

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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 * 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. - 10:00 p.m.): * licensed staff (RN/LPN) = short 20/30 days; averaged one licensed staff short per evening	F 353		

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F 353	Continued From page 32 shift * 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.m. - 6:00 a.m.): * licensed staff (RN/LPN) = short 18/30 days; averaged one licensed staff short per shift * nursing assistants = short 30/30 days: ranged from 3-4 staff short with a an average of 3 staff short per night shift A policy on staffing was requested and none provided.	F 353		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	**F 431- E** Corrective Action: A. Insulin for residents R10, R117, R97, R152, R13, R155, R15, R146, R44, R14, R1, R100, R46, R30, R200, and R18 will be separated by appropriate barrier to prevent cross-contamination for each device and have proper labels with directions. B. Multi-use Insulin pens have been labeled appropriately by the pharmacy. C. Internal and External medications are now stored separately on the medication carts, treatment carts and in the medication rooms and medication refrigerators.	

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F 431	Continued From page 33 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 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: On 10/26/16, from 11:49 a.m. through 12:29 a.m. medication carts on each unit contained insulin pens for a total of 16 residents that were not labeled with directions for use. The insulin pens were only labeled with resident names. R10's signed physician orders dated 10/5/15, indicated R10 had orders for Lantus and Novolog insulin. R10 had Lantus and Novolog insulin pens in the medication cart. R117's signed physician orders dated 10/17/16, Lantus and Humalog insulin. R117 had Lantus	F 431	Corrective Actions as it applies to other Residents: A. The Medication Storage Policy has been reviewed and revised. B. The Labeling of Medications procedure has been educated to all nursing staff. Date of Completion: December 8, 2016 Recurrence will be prevented by: A. Facility staff members were educated on the revised Medication Storage and Labeling of Medications procedure at the All Staff Meetings completed the week of 11-28-16. B. Facility will perform audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly x 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person- DON	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 34 and Novolog insulin pens in the medication cart. R97's signed physician orders dated 10/24/16, indicated R97 had orders for Lantus and Novolog insulin. R97 had a Novolog insulin pen in the medication cart. 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. 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. 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. 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. R146's signed physician orders dated 9/10/16, indicated R146 had orders for Lantus and Novolog insulin. R146 had Lantus and Novolog pens in the medication cart. R44's signed physician orders dated 9/7/16, indicated R44 had orders for Humalog and Lantus insulin. R44 had Humalog and Lantus pens in the medication cart. R41 had Lantus and Novolog insulin pens in the medication cart.	F 431		

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	245227	A. BUILDING _____ B. WING _____	10/27/2016

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F 431	Continued From page 35 R1's signed physician orders dated 9/7/16, indicated R1 had orders for Lantus and Novolog insulin. R1 had Lantus and Novolog insulin pens in the medication cart. 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 physician orders dated 10/17/16, indicated R46 had orders for Lantus and Novolog insulin. R46 had two Lantus insulin pens in the medication cart. R30's signed physician orders dated 10/12/16, indicated R30 had orders for Lantus and Novolog insulin. R30 had Lantus and Novolog pens in the medication cart. R200's signed physician orders dated 10/12/16, indicated R200 had orders for Lantus insulin. R200 had a Lantus insulin pen in the medication cart. R18's signed physician orders dated 9/19/16, indicated R30 had orders for Humalog and Lantus insulin. R18 had Humalog and Lantus in the medication cart. On 10/26/16, at 12:29 p.m. registered nurse (RN)-C verified there were no labels with directions for use on any of the insulin pens. RN-C stated the insulin pens were sent from the pharmacy in bags or boxes with labels on the bag or box. RN-C stated the bag or box had been thrown away after the pen was removed for the first use.	F 431		

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F 431	Continued From page 36 On 10/26/16, at 1:06 p.m. the consultant pharmacist stated the insulin pens should have a label with directions for use on the pen or on the container it is stored in. On 10/27/16, at 3:42 p.m. the director of nursing (DON) verified insulin pens should have the proper labels with directions for use on each package or pen. On 10/26/16, at 12:38 p.m. RN-C stated fentanyl patches (a narcotic pain medicated skin patch) were disposed of in the sharps containers (a container used for the storage of used needles). Sharps containers were secured to the medication carts. The flip-top openings to the sharps containers were not secured. All residents, visitors, and staff had access to the sharps containers when carts were left unattended in the hallways. On 10/26/16, at 1:06 p.m. the consultant pharmacist stated the facility policy should be followed for destruction of medications, but the fentanyl patches should be folded together and flushed in the sewer system. The consultant pharmacist verified the fentanyl patches should not be disposed of in the sharps containers. On 10/27/16, at 10:19 a.m. licensed practical nurse (LPN)-A stated used fentanyl patches were cut up and disposed of in the sharps container. A sharps container was observed on the medication cart in the hallway, unsecured and one on the counter in the room behind the desk with the door open. LPN-A verified findings. All staff access the room to read the communication board and access the refrigerator. LPN-A stated the sharps	F 431		

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F 431	Continued From page 37 containers may be kept in the back room until they were brought down to the locked storage area located outside the facility. LPN-A stated an outside agency/disposal picks the sharps containers up from there. On 10/27/16, at 10:41 a.m. a full sharps container was on the counter in the room behind the desk on the Beachwalk unit. On 10/27/16, at 10:53 a.m. RN-A verified the sharps containers should not be in the room by the desk. RN-A also verified staff had access to the sharps containers, and fentanyl patches are disposed of in the sharps containers. On 10/27/16, at 1:44 p.m. RN-A stated she checked with the pharmacist and the policy and stated they were to be flushing fentanyl patches in the sewer system. RN-A verified some nurses were flushing them and some were putting them into the sharps containers. RN-A identified the biohazard storage bin, where the sharps containers were brought for storage until pick up by the disposal company. The storage bin was a metal shed that was locked, and the key was attached to a cable and hanging on a cable under the roof of the shed, just above the lock. RN-A stated the nurses and the trained medication aides (TMA) knew about the location of the key and the contents of the shed, and also stated maintenance would also know about it. The administrator came outside, to the biohazard storage bin and when asked about the potential for diversion, he stated the key would be removed right away. The key to the biohazard storage bin was removed and brought to a locked drawer on a unit, and the keys to the drawer were to be carried by the nurse.	F 431		

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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. On 10/27/16, at 3:29 p.m. the director of nursing (DON) stated the fentanyl patches should be destroyed by flushing and should not be disposed of in the sharps containers. The DON verified the sharps were available to all staff, visitors, and residents. The DON also verified the key should not be kept on the storage shed for the biohazards. The undated facility policy and procedure for Storage of Medications directed drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The undated facility policy and procedure for Discarding and Destroying Medications directed nursing to destruct controlled substances in a manner that would render it "non-retrievable," no longer usable or available and could not be illegally diverted.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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F 441	Continued From page 39 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and maintain an ongoing, comprehensive infection control surveillance program related to the tracking and trending of infections. This had the potential to effect all 108 residents who resided in the facility. In addition, the facility failed to ensure insulin injectable pens were stored in a manner to prevent cross contamination of blood-borne pathogens for 16 of 16 residents who had insulin	F 441	F 441- F Corrective Action: A. Resident Infections and Employee Illness are now being logged for trending purposes. Corrective Action as it applies to other Residents: A. The Infection Control Surveillance Policy has been revised. B. An Employee Illness Log has been implemented. The Resident Infection Log was reviewed. C. Handwashing training and competency provided to all facility staff. Date of Completion: December 8, 2016 Recurrence will be prevented by: A. Facility Staff received education on hand washing, the Infection Control Surveillance Policy, the Resident Infection Log and the Employee Illness log at the All Staff meetings completed the week of 11-28-16. B. Facility will perform audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly x 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued.	

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F 441	Continued From page 40 pens in the medication cart on all 5 units. In addition, the facility failed to ensure appropriate 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 11:49 a.m. through 12:29 a.m. medication carts on each unit contained insulin pens for a total of 16 residents that were stored together in the same containers/bin or area of the cart, without separation from each other. RN-C verified that there is a risk of cross-contamination of blood borne pathogens by storing the insulin pens together.	F 441		

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F 441	Continued From page 41 R10's physician orders dated 10/17/16, indicated R10 had orders for Lantus insulin. R10 had Lantus and Novolog insulin pens in the medication cart/bin. R117's signed physician orders dated 10/17/16, Lantus and Humalog insulin. R117 had Lantus and Novolog insulin pens in the medication cart/bin. R97's signed physician orders dated 10/24/16, indicated R97 had orders for Lantus and Novolog insulin. R97 had a Novolog insulin pen in the medication cart/bin. 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. R146's signed physician orders dated 9/10/16, indicated R146 had orders for Lantus and Novolog insulin. R146 had Lantus and Novolog	F 441		

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F 441	Continued From page 42 pens in the medication cart/bin. R44's signed physician orders dated 9/7/16, indicated R44 had orders for Humalog and Lantus insulin. R44 had Humalog and Lantus pens in the medication cart/bin. R14 had Lantus and Novolog insulin pens in the medication cart/bin. R1's signed physician orders dated 9/7/16, indicated R1 had orders for Lantus and Novolog insulin. R1 had Lantus and Novolog insulin pens in the medication cart/bin. 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/bin. R46's signed physician orders dated 10/17/16, indicated R46 had orders for Lantus and Novolog insulin. R46 had two Lantus insulin pens in the medication cart/bin. R30's signed physician orders dated 10/12/16, indicated R30 had orders for Lantus and Novolog insulin. R30 had Lantus and Novolog pens in the cart/bin. R200's signed physician orders dated 10/12/16, indicated R200 had orders for Lantus insulin. R200 had a Lantus insulin pen in the medication cart/bin. R18's signed physician orders dated 9/19/16, indicated R30 had orders for Humalog and Lantus insulin. R18 had Humalog and Lantus insulin pens in the medication cart/bin.	F 441		

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F 441	Continued From page 43 On 10/26/16, at 11:59 a.m. the director of nursing (DON) directed the nurses to put the insulin in separate plastic baggies after cleaning them with anti-microbial wipes for blood-borne pathogens. On 10/26/16, at 12:07 p.m. the DON stated that this is a wide spread problem and wiped off each pen with the appropriate antimicrobial wipes. The DON instructed the nurses on each unit to clean the insulin pens with the appropriate wipes and store them separately in a plastic baggie for each resident. On 10/26/16, at 10:12 a.m. nursing assistant (NA)-B assisted R128 with toilet use. NA-B was assisted by NA-M to transfer R128 to the toilet, using the stand-aid lift. NA-B and NA-M had gloves on. NA-B pulled down R128's pants and removed R128's incontinent briefs, which were soiled with urine and bowel movement, and threw the brief in the garbage can. NA-B removed the stand-aid lift from the bathroom, using the same gloved hands. NA-B removed gloves and put on new gloves. NA-B put a new incontinent brief on R128, brought in the stand-aid lift, hooked up the stand aid lift straps, wiped R128's perineum and buttocks with disposable washcloths. NA-B removed gloves and pulled up R128's pants. R128 was brought to his easy chair/recliner for a rest, the recliner's leg rest was put up, a blanket was put on, and a personal alarm was put on R128. NA-B gave R128 his call light. The stand aid lift was brought out of R128's room and down the hall where it was put into a room to store. NA-B stated she was usually very good about washing her hands between glove changes, but when she thought about where the sanitizer was, she realized she probably hadn't washed or	F 441		

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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 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 will be replaced with hard surface 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 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to 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:	F 465		

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F 465	Continued From page 45 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. Room 222, the front legs of the commode over the toilet, were rusty on the bottom approximately half the way up. Room 237, the bathroom floor tile had a white coating as if chipped or rubbed off. Room 248, the bathroom and room door frames were scuffed. The bathroom floor had small holes with inserts which were filled with dirt. Room 252, the wheelchair was dirty and had electrical tape of different colors that were frayed and worn. Room 259, the left wheelchair arm rest had several long tears. Room 263, the carpet in the center of the room 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 HD stated the night nursing assistants (NA) were to take resident's wheelchairs to the wheelchair washer. Wheelchairs were also washed and repaired when a resident discharged. The facility had a computer system that maintains a schedule for maintenance or any staff can make a	F 465	C. The facility has reviewed and revised the Maintenance checklist. Date of Completion: December 8, 2016 Recurrence will be prevented by: A. All Staff will be educated on the expectations to provide a safe, functioning, sanitary, and comfortable environment through all-staff meetings completed the week of 10-28-16. B. Facility will perform audits 4x's per week for 2 weeks, then weekly audits for 4 weeks, then monthly x 3 months. Findings will be reported to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Responsible Person: Administrator	

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F 465	Continued From page 46 computerized request for repairs. The MS further stated 10 rooms were audited every week. A policy was requested but not provided.	F 465		

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

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	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Bayshore Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	**APPROVED** Thomas E Linhoff **By Tom Linhoff at 8:47 am, Dec 12, 2016** RECEIVED DEC - 9 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 11/23/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2016**

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

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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Bayshore Health Center is a 2-story building with a no basement. The original building was constructed in 1969 with an addition in 1978. The original building buildings and additions are all Type II (111) construction, therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 139 beds and had a census of 107 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 2 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.6.3.2. This deficient practice could affect 24 of 107 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 11:00 a.m. to 2:00 p.m. on 10/25/2016, observations revealed that resident rooms 200 and 239 have corridor doors	K 018	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 entire facility: A. All doors within the facility were checked to assure proper closure. Date of Completion: December 8, 2016 Responsible Person: Maintenance Director	

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K 018	Continued From page 3 that did not fully close and latch into the door frames. This deficient condition was verified by a Maintenance Supervisor.	K 018		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility faille to ensure that the automatic sprinkler system is installed in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 1999 edition sections 5-4 and 5-5. This deficient condition is causing a decrease in the fire protection system capability in the event of an emergency that could affect 55 of 107 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 056	K 056- F Corrective Action: A. Sprinkler heads in the main entry receptionist area were switched out by fire protection vendor so all heads are the same response action. Corrective Actions as it applies to the entire facility: A. All fire compartments were assessed to assure there are no mixed action sprinkler heads within a compartment. Date of Completion: December 8, 2016 Responsible Person: Maintenance Director	

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K 056	Continued From page 4 On facility tour between 11:00 a.m. to 2:00 p.m. on 10/25/2016, observation and staff interviews revealed that there are standard and quick response fire sprinkler heads mixed in the same compartment that is located at the main entry receptionist area. This deficient condition was verified by a Maintenance Supervisor.	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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

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

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

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Teresa.Ament@state.mn.us
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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00589	A. BUILDING: _____ B. WING _____	10/27/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 24, 2016 through October 27, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate bathing	2 565		

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2 565	Continued From page 2	2 565		

preferences as directed by the care plan for 1 of 3 residents (R15) reviewed for bathing choices. In addition, the facility failed to ensure the care plan for toilet use was followed for 1 of 3 residents (R128) reviewed for incontinence.

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.

The quarterly Minimum Data Set (MDS) dated 10/6/16, indicated R15 was cognitively intact, and had no behaviors or rejection of cares. The MDS further indicated R15 required staff assistance with bed mobility, transfers, dressing and personal hygiene. The MDS also indicated R15 was occasionally incontinent of bladder. The MDS indicated bathing did not occur during the assessment period. The annual MDS dated 7/7/16, indicated R15 required assistance with bathing, and it was very important for R15 to choose between a tub bath, a shower, a bed or sponge bath.

The care plan revised on 10/5/16, indicated R15 required the extensive assistance of one staff for bathing (including transfer assistance to the shower chair). The nursing assistant (NA) care guide updated on 9/23/16, directed staff to see the bath list for bath days. The Weekly Shower Schedule updated on 10/25/16, indicated R15 was scheduled for a shower on Tuesday and Saturday on the afternoon shift.

The facility's Shower Day Worksheets/Body Sheet Update forms from 9/3/16, through 10/18/16, indicated of 14 opportunities for a

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2 565	Continued From page 3	2 565		

shower, R15 had only received 3 showers. R15 did refuse a shower on 9/24/16, and on 10/15/16 the worksheet indicated staff was unable to do the shower because there was not enough staff available, and they were trying to train new staff.

During observation from 10/25/16, at 8:57 a.m. through 10/27/16, at 2:00 p.m. R15's hair appeared messy and slightly greasy.

On 10/25/16, at 8:57 a.m. R15 stated it had been over a month since he had received a shower. R15 stated staff tell him there was no time to do his shower. R15 further stated he would like a shower a couple of times a week. R15 stated his shower day was Saturday, and he had requested more frequent showers. The facility added a shower on Tuesday, R15 felt he did not get a shower on any day. R15 stated, "If I don't wash my hair every day it sticks up all over the place."

On 10/27/16, at 2:20 p.m. trained medication administrator (TMA)-C stated the staff was unable to get the afternoon baths done as there were only two nursing assistants (NA) on R15's unit, with a float NA between two units.

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.

On 10/27/16, at 2:40 p.m. NA-M stated she worked afternoons on R15's unit. NA-M stated she had never had R15 refuse a shower.

On 10/26/16, at 2:40 p.m. the director of nursing

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2 565	Continued From page 4 (DON) verified the care plan should be followed. A policy on following the care plan was requested but not provided. R128's Admission Record printed 10/26/16, identified diagnoses that included dementia, urinary incontinence, and diverticulosis. R128's admission Minimum Data Set (MDS) dated 10/7/16, indicated R128 had moderate impairment of cognitive skills for daily decision-making. R128 required total assistance with transfers with two staff assist and extensive assist of 2 staff for toilet use. R128's MDS indicated he was always incontinent of urine and frequently incontinent of bowel. 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 Bladder Program Screener, indicated R128 was always incontinent of bladder and required extensive assistance for toilet use. The Bowel and Bladder screener indicated R128 was confused and needed prompting.	2 565		

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2 565	Continued From page 5 On 10/26/16, at 7:41 a.m. continuous observations of R128 were initiated when R128 was brought from therapy in a wheelchair, to the unit common area to watch television. At 7:56 a.m. R128 was brought to the dining room for breakfast. At 8:30 a.m. R128 was brought from the dining room to the common area and set in front of the TV. At 8:50 a.m. R128 was brought to physical therapy. Continuous observations continued through R128's physical therapy session. At 9:11 a.m. certified occupational therapy aide (COTA), who had brought R128 to the common area on the unit before breakfast, as noted, stated she had worked with R128 for 70 minutes earlier and stated she gets at the facility at 6 a.m. and started working with him on upper body cares. The COTA verified she had not worked with R128 on toileting. At 9:52 a.m. R128 continued to work in physical therapy and a slight incontinence odor was detected. At 10:06 a.m. COTA stated staff toileted R128 when they got him up prior to therapy. At 10:07 a.m. the physical therapist took R128 down the hall in his wheelchair. At 10:10 a.m. physical therapist set R128's wheelchair in the common area in front of the TV and left the unit. Staff were not informed R128 had returned from therapy. At 10:12 a.m. nursing assistant (NA)-B brought R128 to his bathroom to use the toilet, which was 2 1/2 hours since initiation of continuous observations and approximately 3 hours and 40 minutes since resident was changed when he was gotten up for therapy the first time. R128's incontinent brief was removed in the bathroom and smelled strongly of urine and also had bowel movement (BM) in the brief. NA-B threw the brief into the garbage. NA-B verified the brief was soiled with urine and BM. NA-B verified R128's incontinent brief had been changed before	2 565		

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2 565	Continued From page 6 therapy the first time, and she had not toileted R128 before therapy took him to therapy again. NA-B stated she usually checks him every 2 hours. On 10/26/16, at 2:40 p.m. the director of nursing (DON) verified the care plan should be followed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate	2 800		

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2 800	Continued From page 7 nursing staff was provided for all 108 residents who resided in the facility. Findings include: See F242 Choices - as the facility failed to provide adequate staffing to accommodate bathing preferences for 1 of 3 residents (R15) reviewed for choices. See F315 Urinary Incontinence - as the facility failed to provide consistent staff assistance with toileting for 1 of 3 residents (R128) observed for urinary incontinence. RESIDENT CONCERNS WITH THE LACK OF ADEQUATE STAFFING: R155's quarterly Minimum Data Set (MDS) dated 8/3/16, indicated R155 was cognitively intact, was totality dependent on staff for assistance with transferring and toileting. On 10/25/16, at 9:50 a.m. R155 stated that she had waited for over an hour for a staff member to answer her call light. R155 stated she started to scream out, and then the staff would finally come. In addition, R155 stated the staff seemed to be rushed when they assisted her with cares and that just didn't feel right. R29's quarterly MDS dated 9/27/16, indicated R29 was cognitively intact and used oxygen therapy. On 10/27/16, at 10:22 a.m. R29 stated there was not enough nursing assistants on the night shift and at times there was only one nurse on who covered both floors at the facility. R29 stated the evening prior he had put his call light on around 12:30 a.m. as R29 required assistance to place his oxygen on for the night. R29 stated the nurse arrived at 2:00 a.m. (an hour and a half	2 800		

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2 800	Continued From page 8 later) and placed his oxygen on him. R29 stated he didn't want to fall asleep until the oxygen had been placed as he needed the supplemental oxygen at night when he slept. R29 stated at times the nursing assistants would come in and turn the call light off and say they would be right back, and then they didn't come back. R29 stated he didn't like when the staff turned the call light off before they addressed his needs. FAMILY CONCERNS WITH LACK OF ADEQUATE STAFFING: When interviewed on 10/27/16, at 11:00 a.m. family member (FM)-A stated his wife was totally dependent on staff for cares. FM-A stated on 10/25/16, during the evening shift when he was visiting his wife, she had been incontinent of bowel and a nursing assistant told FM-A that they needed to get some help to clean her up. FM-A stated the nursing assistant wasn't able to find anyone to help so his wife sat in BM for two hours before the nursing assistants returned to clean her up. FM-A stated at times he needed to help his wife with her cares because there wasn't enough staff working. FM-A stated, "It would be nice if I didn't have to worry about her all the time." FM-A stated he felt frustrated and it broke his heart that she wasn't receiving the care she needed or deserved. FM-A stated he routinely came the facility to visit his wife twice a day. STAFF CONCERNS: On 10/25/16, at 10:58 a.m. nursing assistant (NA)-A, who also worked as a trained medication aide (TMA), stated she appreciated when the surveyors were at the facility as they seemed to be fully staffed. NA-A stated the nursing assistants had a hard time getting residents	2 800		

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2 800	Continued From page 9	2 800		

toileted and repositioned on time. NA-A stated when she had worked as a TMA, she tried to help the nursing assistants out when she could, however, then she was late on administering the resident's medications.

On 10/26/16, at 7:12 a.m. NA-E stated the facility had been short staff lately. NA-E stated she worked a lot of extra shifts because they were short staffed.

On 10/26/16, at 7:15 a.m. while conducting a dressing change on R18 licensed practical nurse (LPN)-B stated, she continued to work at the facility because they needed her. LPN-B stated the residents didn't always get their basic needs met like being offered fresh water and turned when they should be turned. LPN-B stated she felt that was why the facility had residents that developed pressure ulcers and had become septic.

On 10/26/16, at 9:11 a.m. NA-F stated at times she was unable to get her work completed even though the NA's tried very hard. NA-F confirmed during survey time the facility seemed to schedule more staff.

On 10/26/16, at 10:12 a.m. NA-B stated staffing was hard. NA-B was the only person on the locked dementia unit with eight residents. NA-B stated she called for help from another unit when she needed to transfer a resident.

On 10/26/16, at 11:34 a.m. NA-G stated things needed to be more organized at the facility. NA-G stated she worked full time and every two week period she was mandated to stay and work an extended shift. NA-G stated most of the time she was not able to get her work done. NA-G

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2 800	Continued From page 10 stated residents did not get repositioned on time or changed when they should. In addition, NA-G stated she didn't get her charting completed. NA-G stated the residents that could not speak up for themselves may not get the care they needed, because they were unable to remind the staff when they needed something. NA-G stated they no longer had a bath aide, so the nursing assistants also had to do so many baths a day besides completing their other duties. On 10/2716, at 8:23 a.m. LPN-C stated the facility was routinely short staffed. LPN-C stated she was able to complete her work because she stayed beyond her scheduled time and that was when she charted. On 10/27/16, at 9:20 a.m. NA-H confirmed she was asked to stay late either a partial or full shift ever shift she worked. NA-H stated she was mandated to stay once every two week scheduling period. NA-H stated at times there was more than one staff member who was mandated to stay for the same shift. NA-H stated one weekend five staff members from the day shift were mandated to stay for the evening shift. NA-H stated there was not enough staff members to get the work completed. NA-H stated things got missed or delayed like brushing residents teeth, getting residents turned or repositioned on time, and checking and changing residents who were incontinent. NA-H stated sometimes it took her until noon to complete morning cares. NA-H stated normally she was assigned about 10 residents, however since most of the residents required two staff members, the nursing assistants just tried to work as a team. On 10/27/16, at 9:31 a.m. NA-I stated she had been mandated to stay over on her third day of	2 800		

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2 800	Continued From page 11 orientation. NA-I stated she felt there were not enough staff to care for the residents. NA-I stated there were only two nursing assistants for 36 residents on the day shift, with only five of the residents who were fairly independent. NA-I stated she had seen staff hurt themselves because they had lifted residents by themselves and should have had two staff members assisting with the transfer. NA-I stated she was aware of residents who were not turned, repositioned, or toileted timely due to not having enough staff available. On 10/27/16, at 10:24 a.m. NA-J, who also works as a TMA, stated when she worked as a TMA she was always pulled away to assist the nursing assistants. NA-J stated when she worked as a TMA, she would have 34 residents which she was assigned and responsible for passing their medications, providing treatments, monitoring residents' blood sugars, and administering insulin. NA-J stated there had been times when one nurse was assigned 51 residents to pass medications on. NA-J stated resident cares do not get done. NA-J stated she was aware of residents who were not able to speak for themselves and who required two staff to assist them with transfers, had sat up in their wheelchairs in the common area from 7:00 a.m. until 1:00 p.m. without being repositioned or changed. NA-J stated residents are not getting their baths, especially on the second floor units where there are only two nursing assistants scheduled for 34-36 residents. NA-J stated the facility was always running short of staff. NA-J stated two weeks ago they only had one nursing assistant for 24 residents, so she called someone in, and she worked as a nursing assistant and the other staff member took on NA-J's duties to pass medications.	2 800		

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2 800	Continued From page 12 On 10/27/16, at 10:32 a.m. NA-H stated the residents who cannot speak up for themselves or put on their call light had not received the care they needed because there wasn't enough staff to provide the care. On 10/27/16, at 1:18 p.m. interview conducted with director of nursing (DON), the scheduler and human resource director (HRD). HRD stated staffing was one of biggest challenges the facility had. DON stated they had asked at the resident council meetings if the residents had any concerns with timeliness of call lights being answered. DON stated this had not been brought up as an area of concern by those residents who attended the resident council. DON confirmed the facility had not conducted any type of call light response time audit. However, the facility was actively advertising their open positions. DON confirmed the facility was not using any agency 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,	2 800		

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2 800	Continued From page 13 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 * 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. - 10:00 p.m.): * licensed staff (RN/LPN) = short 20/30 days; averaged one licensed staff short per evening shift * 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.m. - 6:00 a.m.): * licensed staff (RN/LPN) = short 18/30 days; averaged one licensed staff short per shift * nursing assistants = short 30/30 days: ranged from 3-4 staff short with a an average of 3 staff short per night shift A policy on staffing was requested and none provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies, review and adjust scheduling needs in order to ensure staffing needs are met. Education could be provided to all staff. The	2 800		

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2 800	Continued From page 14 administrator or designee could develop an auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 800		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure toileting assistance was provided for 1 of 3 residents (R128) reviewed for incontinence. Findings include: R128's Admission Record printed 10/26/16, identified diagnoses that included dementia, urinary incontinence, and diverticulosis.	2 910		

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2 910	Continued From page 15 R128's admission Minimum Data Set (MDS) dated 10/7/16, indicated R128 had moderate impairment of cognitive skills for daily decision-making. R128 required total assistance with transfers with two staff assist and extensive assist of 2 staff for toilet use. R128's MDS indicated he was always incontinent of urine and frequently incontinent of bowel. 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 Bladder Program Screener, indicated R128 was always incontinent of bladder and required extensive assistance for toilet use. The Bowel and Bladder screener indicated R128 was confused and needed prompting. On 10/26/16, at 7:41 a.m. continuous observations of R128 were initiated when R128 was brought from therapy in a wheelchair, to the unit common area to watch television. At 7:56 a.m. R128 was brought to the dining room for breakfast. At 8:30 a.m. R128 was brought from the dining room to the common area and set in front of the TV. At 8:50 a.m. R128 was brought to physical therapy. Continuous observations	2 910		

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2 910	Continued From page 16 continued through R128's physical therapy session. At 9:11 a.m. certified occupational therapy aide (COTA), who had brought R128 to the common area on the unit before breakfast, as noted, stated she had worked with R128 for 70 minutes earlier and stated she gets at the facility at 6 a.m. and started working with him on upper body cares. The COTA verified she had not worked with R128 on toileting. At 9:52 a.m. R128 continued to work in physical therapy and a slight incontinence odor was detected. At 10:06 a.m. COTA stated staff toileted R128 when they got him up prior to therapy. At 10:07 a.m. the physical therapist took R128 down the hall in his wheelchair. At 10:10 a.m. physical therapist set R128's wheelchair in the common area in front of the TV and left the unit. Staff were not informed R128 had returned from therapy. At 10:12 a.m. nursing assistant (NA)-B brought R128 to his bathroom to use the toilet, which was 2 1/2 hours since initiation of continuous observations and approximately 3 hours and 40 minutes since resident was changed when he was gotten up for therapy the first time. R128's incontinent brief was removed in the bathroom and smelled strongly of urine and also had bowel movement (BM) in the brief. NA-B threw the brief into the garbage. NA-B verified the brief was soiled with urine and BM. NA-B verified R128's incontinent brief had been changed before therapy the first time, and she had not toileted R128 before therapy took him to therapy again. NA-B stated she usually checks him every 2 hours. On 10/26/16, at 2:40 p.m. the director of nursing (DON) stated R128 should be offered toilet use every 2 hours and verified the care plan should be followed.	2 910		

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2 910	Continued From page 17 A policy and procedure for following the care plan for toilet use was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement systems to ensure residents were toileted based on a comprehensive assessment and plan of care. The DON or designee could educate all appropriate staff. The DON or designee could monitor this process to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and maintain an ongoing, comprehensive infection control surveillance program related to the tracking and trending of infections. This had the potential to effect all 108 residents who resided in the facility. In addition, the facility failed to ensure insulin injectable pens were stored in a manner to prevent cross contamination of blood-borne pathogens for 16 of 16 residents who had insulin pens in the medication cart on all 5 units. In addition, the facility failed to ensure appropriate	21375		

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21375	Continued From page 18 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 11:49 a.m. through 12:29 a.m. medication carts on each unit contained insulin pens for a total of 16 residents that were stored together in the same containers/bin or area of the cart, without separation from each other. RN-C verified that there is a risk of cross-contamination of blood borne pathogens by storing the insulin pens together. R10's physician orders dated 10/17/16, indicated R10 had orders for Lantus insulin. R10 had Lantus and Novolog insulin pens in the medication cart/bin. R117's signed physician orders dated 10/17/16, Lantus and Humalog insulin. R117 had Lantus and Novolog insulin pens in the medication cart/bin.	21375		

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21375	Continued From page 19 R97's signed physician orders dated 10/24/16, indicated R97 had orders for Lantus and Novolog insulin. R97 had a Novolog insulin pen in the medication cart/bin. 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. R146's signed physician orders dated 9/10/16, indicated R146 had orders for Lantus and Novolog insulin. R146 had Lantus and Novolog pens in the medication cart/bin. R44's signed physician orders dated 9/7/16, indicated R44 had orders for Humalog and Lantus insulin. R44 had Humalog and Lantus pens in the medication cart/bin. R14 had Lantus and Novolog insulin pens in the medication cart/bin. R1's signed physician orders dated 9/7/16, indicated R1 had orders for Lantus and Novolog	21375		

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21375	Continued From page 20 insulin. R1 had Lantus and Novolog insulin pens in the medication cart/bin. 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/bin. R46's signed physician orders dated 10/17/16, indicated R46 had orders for Lantus and Novolog insulin. R46 had two Lantus insulin pens in the medication cart/bin. R30's signed physician orders dated 10/12/16, indicated R30 had orders for Lantus and Novolog insulin. R30 had Lantus and Novolog pens in the cart/bin. R200's signed physician orders dated 10/12/16, indicated R200 had orders for Lantus insulin. R200 had a Lantus insulin pen in the medication cart/bin. R18's signed physician orders dated 9/19/16, indicated R30 had orders for Humalog and Lantus insulin. R18 had Humalog and Lantus insulin pens in the medication cart/bin. On 10/26/16, at 11:59 a.m. the director of nursing (DON) directed the nurses to put the insulin in separate plastic baggies after cleaning them with anti-microbial wipes for blood-borne pathogens. On 10/26/16, at 12:07 p.m. the DON stated that this is a wide spread problem and wiped off each pen with the appropriate antimicrobial wipes. The DON instructed the nurses on each unit to clean the insulin pens with the appropriate wipes and store them separately in a plastic baggie for each resident.	21375		

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21375	Continued From page 21 On 10/26/16, at 10:12 a.m. nursing assistant (NA)-B assisted R128 with toilet use. NA-B was assisted by NA-M to transfer R128 to the toilet, using the stand-aid lift. NA-B and NA-M had gloves on. NA-B pulled down R128's pants and removed R128's incontinent briefs, which were soiled with urine and bowel movement, and threw the brief in the garbage can. NA-B removed the stand-aid lift from the bathroom, using the same gloved hands. NA-B removed gloves and put on new gloves. NA-B put a new incontinent brief on R128, brought in the stand-aid lift, hooked up the stand aid lift straps, wiped R128's perineum and buttocks with disposable washcloths. NA-B removed gloves and pulled up R128's pants. R128 was brought to his easy chair/recliner for a rest, the recliner's leg rest was put up, a blanket was put on, and a personal alarm was put on R128. NA-B gave R128 his call light. The stand aid lift was brought out of R128's room and down the hall where it was put into a room to store. NA-B stated she was usually very good about washing her hands between glove changes, but when she thought about where the sanitizer was, she realized she probably hadn't washed or 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.	21375		

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21375	Continued From page 22 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop, review, and/or revise policies and procedures to ensure an infection control program that includes implementation. The director of nursing or designee could educate all appropriate staff on the policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced	21426		

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21426	Continued From page 23 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 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 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 received the first step TST on 6/6/16. On 6/16/16, (10 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. R135 was admitted to the facility on 4/26/16. No	21426		

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21426	Continued From page 24	21426		

baseline TB screening was completed. R135's EMR indicated R 135 received the first step TST on 4/26/16, and was not read. R 135 did not receive a second step TST.

R143 was admitted to the facility on 7/12/16. No baseline TB screening was completed. R143's EMR indicated R 143 received the first step TST on 7/13/16. On 7/15/16, the first step TST was read as negative with no induration documentation. On 7/26/16, R143's second step TST was administered. On 7/28/16, R143's step two TST was read as negative, with 0 mm of induration.

R145 was admitted to the facility on 7/26/16. No baseline TB screening was completed. R145's EMR indicated she received the first step TST on 7/27/16, and was not read. On 8/8/16, R145 received an additional first step TST. On 8/10/16, this was read as unable to determine with 5 mm induration . R 145 did not receive a second step TST.

E-A who was hired on 7/20/16. No baseline TB screening was completed. E-A's first step TST was administered on 7/20/16, and was not read. E-A did not receive a second step TST.

E-B who was hired on 9/19/16. No baseline TB screening was completed. E-B's first step TST was administered on 9/19/16, and was not read. E-B did not receive a second step TST.

E-C who was hired on 8/23/16. Baseline TB screening was completed on 10/19/16. E-C's first step TST was administered on 8/23/16, and was not read. E-C received a second step TST on 10/20/16, and not read.

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21426	Continued From page 25 E-D who was hired on 8/1/16. No baseline TB screening completed. E-D's first step TST was administered 8/1/16, and was not read. E-D did not receive a second step TST. E-E who was hired on 8/23/16. Baseline TB screening completed on 10/19/16. E-E's first step TST was completed on 10/19/16. On 10/21/16, the first step TST was read as 0 mm induration, negative. E-E did not receive a second step TST. On 10/27/16, at 2:10 p.m. the director of nursing (DON) was interviewed. The DON verified the TB program was not being completed. The facility's Tuberculosis Infection Control Program policy (undated) directed screening and surveillance of residents and employees for latent TB infection, and active TB as appropriate. In addition, when reading the TST, staff should confirm that the TST had been administered 48-72 hours prior to reading. The second step of the TST must be repeated within 1-3 weeks after the date the initial TST was read. All test results must be read in mm. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure tuberculosis screening is completed for all new employees and residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21610	Continued From page 26	21610		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. 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: On 10/26/16, from 11:49 a.m. through 12:29 a.m. medication carts on each unit contained insulin pens for a total of 16 residents that were not labeled with directions for use. The insulin pens were only labeled with resident names. R10's signed physician orders dated 10/5/15, indicated R10 had orders for Lantus and Novolog insulin. R10 had Lantus and Novolog insulin pens in the medication cart. R117's signed physician orders dated 10/17/16, Lantus and Humalog insulin. R117 had Lantus and Novolog insulin pens in the medication cart. R97's signed physician orders dated 10/24/16, indicated R97 had orders for Lantus and Novolog insulin. R97 had a Novolog insulin pen in the	21610		

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21610	Continued From page 27 medication cart. 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. 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. 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. 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. R146's signed physician orders dated 9/10/16, indicated R146 had orders for Lantus and Novolog insulin. R146 had Lantus and Novolog pens in the medication cart. R44's signed physician orders dated 9/7/16, indicated R44 had orders for Humalog and Lantus insulin. R44 had Humalog and Lantus pens in the medication cart. R41 had Lantus and Novolog insulin pens in the medication cart. R1's signed physician orders dated 9/7/16, indicated R1 had orders for Lantus and Novolog insulin. R1 had Lantus and Novolog insulin pens in the medication cart.	21610		

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21610	Continued From page 28 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 physician orders dated 10/17/16, indicated R46 had orders for Lantus and Novolog insulin. R46 had two Lantus insulin pens in the medication cart. R30's signed physician orders dated 10/12/16, indicated R30 had orders for Lantus and Novolog insulin. R30 had Lantus and Novolog pens in the medication cart. R200's signed physician orders dated 10/12/16, indicated R200 had orders for Lantus insulin. R200 had a Lantus insulin pen in the medication cart. R18's signed physician orders dated 9/19/16, indicated R30 had orders for Humalog and Lantus insulin. R18 had Humalog and Lantus in the medication cart. On 10/26/16, at 12:29 p.m. registered nurse (RN)-C verified there were no labels with directions for use on any of the insulin pens. RN-C stated the insulin pens were sent from the pharmacy in bags or boxes with labels on the bag or box. RN-C stated the bag or box had been thrown away after the pen was removed for the first use. On 10/26/16, at 1:06 p.m. the consultant pharmacist stated the insulin pens should have a label with directions for use on the pen or on the container it is stored in. On 10/27/16, at 3:42 p.m. the director of nursing	21610		

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21610	Continued From page 29 (DON) verified insulin pens should have the proper labels with directions for use on each package or pen. On 10/26/16, at 12:38 p.m. RN-C stated fentanyl patches (a narcotic pain medicated skin patch) were disposed of in the sharps containers (a container used for the storage of used needles). Sharps containers were secured to the medication carts. The flip-top openings to the sharps containers were not secured. All residents, visitors, and staff had access to the sharps containers when carts were left unattended in the hallways. On 10/26/16, at 1:06 p.m. the consultant pharmacist stated the facility policy should be followed for destruction of medications, but the fentanyl patches should be folded together and flushed in the sewer system. The consultant pharmacist verified the fentanyl patches should not be disposed of in the sharps containers. On 10/27/16, at 10:19 a.m. licensed practical nurse (LPN)-A stated used fentanyl patches were cut up and disposed of in the sharps container. A sharps container was observed on the medication cart in the hallway, unsecured and one on the counter in the room behind the desk with the door open. LPN-A verified findings. All staff access the room to read the communication board and access the refrigerator. LPN-A stated the sharps containers may be kept in the back room until they were brought down to the locked storage area located outside the facility. LPN-A stated an outside agency/disposal picks the sharps containers up from there. On 10/27/16, at 10:41 a.m. a full sharps container was on the counter in the room behind the desk	21610		

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21610	Continued From page 30 on the Beachwalk unit. On 10/27/16, at 10:53 a.m. RN-A verified the sharps containers should not be in the room by the desk. RN-A also verified staff had access to the sharps containers, and fentanyl patches are disposed of in the sharps containers. On 10/27/16, at 1:44 p.m. RN-A stated she checked with the pharmacist and the policy and stated they were to be flushing fentanyl patches in the sewer system. RN-A verified some nurses were flushing them and some were putting them into the sharps containers. RN-A identified the biohazard storage bin, where the sharps containers were brought for storage until pick up by the disposal company. The storage bin was a metal shed that was locked, and the key was attached to a cable and hanging on a cable under the roof of the shed, just above the lock. RN-A stated the nurses and the trained medication aides (TMA) knew about the location of the key and the contents of the shed, and also stated maintenance would also know about it. The administrator came outside, to the biohazard storage bin and when asked about the potential for diversion, he stated the key would be removed right away. The key to the biohazard storage bin was removed and brought to a locked drawer on a unit, and the keys to the drawer were to be carried by the nurse. On 10/27/16 at 2:19 p.m. TMA-B stated fentanyl patches were disposed of in the sharps container. On 10/27/16, at 3:29 p.m. the director of nursing (DON) stated the fentanyl patches should be destroyed by flushing and should not be disposed of in the sharps containers. The DON verified the sharps were available to all staff, visitors, and	21610		

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21610	Continued From page 31 residents. The DON also verified the key should not be kept on the storage shed for the biohazards. The undated facility policy and procedure for Storage of Medications directed drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The undated facility policy and procedure for Discarding and Destroying Medications directed nursing to destruct controlled substances in a manner that would render it "non-retrievable," no longer usable or available and could not be illegally diverted. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures to ensure that medications are stored and disposed of properly. The director of nursing or designee could educate staff on these policies and procedures. The director of nursing or designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21610		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by:	21665		

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21665	Continued From page 32 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: 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. Room 222, the front legs of the commode over the toilet, were rusty on the bottom approximately half the way up. Room 237, the bathroom floor tile had a white coating as if chipped or rubbed off. Room 248, the bathroom and room door frames were scuffed. The bathroom floor had small holes with inserts which were filled with dirt. Room 252, the wheelchair was dirty and had electrical tape of different colors that were frayed and worn. Room 259, the left wheelchair arm rest had several long tears. Room 263, the carpet in the center of the room	21665		

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	00589	A. BUILDING: _____ B. WING _____	10/27/2016

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21665	Continued From page 33 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 HD stated the night nursing assistants (NA) were to take resident's wheelchairs to the wheelchair washer. Wheelchairs were also washed and repaired when a resident discharged. The facility had a computer system that maintains a schedule for maintenance or any staff can make a computerized request for repairs. The MS further stated 10 rooms were audited every week. A policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Maintenance or designee could develop, review, and/or revise policies and procedures to ensure a safe, clean, homelike environment. The Director of Maintenance or designee could educate all appropriate staff on the policies and procedures. The Director of Maintenance or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate	21830		

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in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance

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directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper

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21830	Continued From page 36 or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bathing frequency preferences for 1 of 3 residents (R15) reviewed for choices. 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. The quarterly Minimum Data Set (MDS) dated 10/6/16, indicated R15 was cognitively intact, and had no behaviors or rejection of cares. The MDS further indicated R15 required staff assistance with bed mobility, transfers, dressing and personal hygiene. The MDS also indicated R15 was occasionally incontinent of bladder. The MDS indicated bathing did not occur during the assessment period. The annual MDS dated 7/7/16, indicated R15 required assistance with bathing, and it was very important for R15 to choose between a tub bath, a shower, a bed or sponge bath. The care plan revised on 10/5/16, indicated R15 required the extensive assistance of one staff for bathing (including transfer assistance to the shower chair). The nursing assistant (NA) care guide updated on 9/23/16, directed staff to see the bath list for bath days. The Weekly Shower Schedule updated on 10/25/16, indicated R15 was scheduled for a shower on Tuesday and	21830		

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21830	Continued From page 37 Saturday on the afternoon shift. The facility's Shower Day Worksheets/Body Sheet Update forms from 9/3/16, through 10/18/16, indicated of 14 opportunities for a shower, R15 had only received 3 showers. R15 did refuse a shower on 9/24/16, and on 10/15/16 the worksheet indicated staff was unable to do the shower because there was not enough staff available, and they were trying to train new staff. During observation from 10/25/16, at 8:57 a.m. through 10/27/16, at 2:00 p.m. R15's hair appeared messy and slightly greasy. On 10/25/16, at 8:57 a.m. R15 stated it had been over a month since he had received a shower. R15 stated staff tell him there was no time to do his shower. R15 further stated he would like a shower a couple of times a week. R15 stated his shower day was Saturday, and he had requested more frequent showers. The facility added a shower on Tuesday, R15 felt he did not get a shower on any day. R15 stated, "If I don't wash my hair every day it sticks up all over the place." On 10/27/16, at 2:20 p.m. trained medication administrator (TMA)-C stated the staff was unable to get the afternoon baths done as there were only two nursing assistants (NA) on R15's unit, with a float NA between two units. 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.	21830		

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21830	Continued From page 38 On 10/27/16, at 2:40 p.m. NA-M stated she worked afternoons on R15's unit. NA-M stated she had never had R15 refuse a shower. On 10/27/16, at 3:20 p.m. the director of nursing (DON) stated he would expect a resident who was scheduled a bath twice a week, to receive a bath twice week. If a resident did not receive a bath, the DON would expect the refusal to be recorded, with the reason why the resident refused. The DON would then expect the resident to be offered a bath the next day, and/or find out why a resident refused a bath and reassess. The DON would expect refusals be documented in the medical record. The DON stated the NA care sheets were derived from the care plan. The care plan was built and the information was carried over to the NA care sheets. The facility was unable to provide a policy on resident choices. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement systems to ensure resident's choices were honored. The DON or designee could educate all appropriate staff. The DON or designee could monitor this process to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases	21995		

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21995	Continued From page 39 of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State Agency (SA) potential allegations of mistreatment for 4 of 4 residents residents (R130, R30, R61, R76) reviewed for abuse. Findings include: The facility did not immediately report an alleged incident of mistreatment against R130 to the state agency; an incident report occurred on 3/6/16, and was submitted on 3/7/16 (time unknown) to the SA. R130's Admission Record identified diagnoses that included need for assist with personal care and reduced mobility. R130's quarterly Minimum Data Set (MDS) dated 9/29/16, indicated R130 was cognitively intact, and used a walker and a wheelchair for mobility devices. R130's care plan dated 1/25/16, indicated he was at increased risk for injury/abuse from others due to physical impairments and low mobility. On 10/24/16, at 3:52 p.m. R130 stated he was physically abused by another resident (R107). R130 stated he was punched in the stomach by another resident. R130 stated he told staff and nothing was done except putting a mesh stop	21995		

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21995	Continued From page 40 sign across his room door. According to the facility's incident report to the State Agency (SA), R130 was lightly hit in the stomach by another resident, R107, on 3/6/16. Progress notes with the incident report indicated R107 made multiple attempts to enter R130's room that shift, and at one point in time approached tightening his fists. The note further indicated R107 was hovering around R130's room causing R130 some concern. On 10/26/16, at 12:33 p.m. social worker (SW)-A stated she wasn't immediately notified of the incident involving R130. SW-A states when she got the information and reviewed it, she knew it was reportable, and the incident was then reported to the SA. On 10/27/16, at 8:54 a.m. R130 stated he didn't like how the incident was handled. R130 stated he felt as if he was doing something wrong. R130 stated R107 would stand in the hall and block his progress and R107 would stare at his door. R130 stated staff would close his door if they felt R107 was targeting him. R130 stated R107 targeted him after the incident too. R130 stated R107 didn't know what he was doing, so he wasn't mad at him, but at the staff for not addressing it. R130 stated change was really slow in coming and it wasn't until R107's medications were changed that he stopped targeting him. R130 stated then it felt like a R107 was a whole new person. The facility did not immediately report an alleged incident of mistreatment (neglect) against R30 to the SA. An incident occurred the evening of 9/21/16; an incident report was submitted on 9/23/16 (time unknown).	21995		

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21995	Continued From page 41 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	21995		

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21995	Continued From page 42 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. On 9/3/16, a behavior/mood note indicated R53 slammed R61's hand in his door, because she was in his room. R53 was educated on pressing his call light to call for assistance, at which R53 replied "whatever" and closed his door. On 9/7/16, a progress note in R61's medical record indicated that on 9/3/16, R61 wandered into another resident's room, and before R61 could be redirected, the other resident closed the door on R61's hand. R61 stated that her hand did hurt. The physician was updated, and orders were received to ice the hand, and monitor for two days. 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	21995		

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21995	Continued From page 43 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	21995		

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21995	Continued From page 44 DON or the administrator are called by staff. On 10/26/16, at 1:39 p.m. the administrator stated he expects to be notified of any potential reportable incident immediately, not to exceed 24 hours. The administrator stated staff will call him, the DON or SW-A, who are the facility's contacts regarding abuse prohibition. The administrator stated he or SW-A are often the staff that determine if an event is reportable. The administrator stated the SA should be notified the same way as he is notified: immediately not to exceed 24 hours. The administrator added the report should be made as soon as is practicable. The administrator stated leadership report immediately after they are made aware of an incident. The administrator stated if an incident of potential mistreatment occurred on a Saturday afternoon, the report should be made then. The administrator stated they educate staff annually on abuse prohibition. The facility Abuse Prohibition Plan dated 5/20/16, directed staff to report suspected maltreatment immediately through either the internal or external report systems. The policy directed staff to begin an internal investigation immediately. The policy further directed staff report suspected abuse internally to the administrator, social service director or DON, and if these individuals are not in the building, staff are to report to the nursing supervisor, nurse manager or team leader at the time of suspicion. The policy directed reporting takes place but lacked specification of the timeframe for that reporting. The policy indicated internal investigation of suspect abuse begins immediately. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop	21995		

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21995	Continued From page 45 policies regarding abuse prohibition. The administrator or designess could educate all staff on these policies. The administrator or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		