DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

June 22, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: March 10, 2022

Dear Administrator:

On May 6, 2022, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On May 11, 2022, the Minnesota Department of Health, completed a revisit and on June 16, 2022 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 11, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 21, 2022, 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 April 15, 2022.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

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June 22, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Re: Reinspection Results
Event ID: P34K12

Dear Administrator:

On May 11, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 11, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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March 21, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: March 10, 2022

Dear Administrator:

On March 10, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

## DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 10, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 10, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Electronically delivered
March 21, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Re: State Nursing Home Licensing Orders
Event ID: P34K11

Dear Administrator:

The above facility was surveyed on March 8, 2022 through March 10, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 immediately contact:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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,

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

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245227 | A. BUILDING _____ B. WING _____ | C 03/10/2022 |

| 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<br><br>On 3/8/22, through 3/10/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be UNSUBSTANTIATED: H5227165C (MN81279, MN80919).<br><br>The following complaint was found to be SUBSTANTIATED: H5227166C (MN81527), however, NO deficiencies were cited due to actions implemented by the facility prior to survey.<br><br>The following complaint was found to be SUBSTANTIATED: H5227164C (MN81557) with deficiencies cited at F580 and F600.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, | F 580 | | 3/29/22 |

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

Electronically Signed | 03/23/2022

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 580 | Continued From page 1 | F 580 | | |

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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

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|---|---|---|---|---|
| F 580 | Continued From page 2<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to notify family of allegations of neglect for 1 of 3 residents (R1) reviewed for notification of change.<br><br>Findings include:<br><br>R1's Face Sheet printed 3/10/22, indicated R1's diagnoses included heart failure, dementia without behavior disturbance, osteoarthritis, depression and a history of COVID-19.<br><br>R1's significant change Minimum Data Set (MDS) dated 2/5/22, indicated R1 needed limited assistance from staff with bed mobility and transfers. R1 needed extensive assistance from staff with dressing, hygiene and toilet use. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's weight was 275 pounds.<br><br>An incident report dated 2/26/22, at 5:29 p.m. indicated R1 reported to registered nurse (RN)-B on 2/25/22, staff had assisted him into the recliner. R1 reported he was stuck all night and felt "trapped". R1 also reported he was wet all night and he was unable to call for assistance because his call light was across the room. The facility took action by notifying the RN case manager (RN-A), and RN-B placed a sign on R1's door which indicated to make sure that the call light was within reach. The report indicated RN-B talked with the day shift nursing assistants (NA) and verified R1 was in the recliner at the start of their shift. The incident further indicated on 3/3/22, the interdisciplinary team (IDT) reviewed the incident report. The staff were | F 580 | R1 family representative and MD was made aware of this incident and their response will be recorded in the resident electronic medical record. R1 had a risk management incident created and thoroughly investigated. R1 care plan was reviewed and updated as needed. From survey exit until present, existing resident incidents related to allegations of abuse were reviewed for family/MD notification. Missing notification was made as needed.<br>Future resident incidents, the family and MD will be notified of abuse allegations and change in condition per policy.<br>Nursing and IDT team was in-serviced on the Abuse/Investigation/Reporting Policy and Procedure with emphasis on item #1 in which the MD, Attending Physician, Family, State Agency and Ombudsman will be notified of alleged allegations. In addition, the IDT team was in-serviced on notifying the MD/NP and family on changes in resident condition.<br>Social Services and/or designee will be responsible for compliance.<br>Audits on abuse allegation notification and resident change in condition notification will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure compliance.<br>Audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation.<br>Compliance: 3/29/2022 | |

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| F 580 | Continued From page 3 | F 580 | | |

educated to assure the call light was within reach at all times. A second call light would be obtained for use when R1 was in the recliner. The incident report lacked indication if the incident was reported to R1's family.

On 3/9/22, at 9:45 a.m. R1 was observed in his room sitting in the wheelchair in front of the television. The call light was tied to the transfer bar on R1's bed, and another call light was laying on the floor behind R1. A sign was posted on the back of R1's door which indicated, "Make sure call light is within reach." R1 was asked if he was able to use his call light. R1 was unable to find the call light nearest to him due to the call light being on the floor, but was able to move himself in the wheelchair over to the bed to use the call light. When asked about using the recliner to rest or sleep in, R1 stated he was 93 years old, a tall guy, and the recliner was too small and too low.

On 3/9/22, at 1:12 p.m. FM-A was interviewed. FM-A stated he had not been notified of the incident where R1 had been left all night in the recliner without his call light, and had not been checked on all night by staff. FM-A stated R1 told him he could not sit in the recliner because the recliner was too low and he could not get out of it. FM-A stated he believed this incident was neglect, it was inexcusable and had better not happen again. FM-A stated he was angry the facility did not tell him.

On 3/9/22, at 1:26 p.m. the director of nursing (DON) was interviewed, and stated on the evening of 2/25/22, R1 was placed in the recliner, and ended up staying in the recliner all night long, without the call light, and without staff checking on him. The DON stated R1 had reported this to

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| F 580 | Continued From page 4 | F 580 | | |

RN-B the morning of 2/26/22. The DON stated she was not informed of the incident until the Monday morning meeting on 2/28/22. The DON verified the incident report and the progress notes lacked indication if family member (FM)-A had been notified of the incident. The DON stated she would expect FM-A be notified.

On 3/9/22, at 2:37 p.m. RN-B stated she has worked at the facility since 10/21, and usually worked the day shift. R1 reported the incident to her on 2/26/22, between 7:00 a.m. and 9:30 a.m. RN-B stated R1 was on precautions because of COVID-19, therefore, the door to his room was kept closed. RN-B stated R1 was upset, mad, and said he should report this place or staff. R1 reported to RN-B he was stuck in the recliner chair all night. RN-B verified with the NAs R1 was in the recliner at the start of the shift. The NAs did not confirm if R1 was wet or not. RN-B stated she was the first staff R1 told. RN-B reported R1's complaint to RN-A in person that afternoon. RN-B told next shift nurse in report to make sure they do quality checks, to ensure he was dressed, dry, and had the call light. In addition, RN-B stated she would usually notify the DON, but she had not.

On 3/10/22, at 9:10 a.m. a follow-up interview was conducted with R1. R1 was observed in his room bent forward in the wheelchair sleeping. R1 stated he was awake until midnight, had slept in his wheelchair, and had not slept well. R1 stated he could not sleep in the bed because when he laid down he had difficulty with phlegm coming up and he coughed uncontrollably. R1 further stated he could not sleep in the recliner in his room because it was too low, and he could not get out of it without help. R1 stated he was six foot one,

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| F 580 | Continued From page 5<br>his knees were above the arms of the recliner and he felt trapped in the recliner. R1 stated the recliner was comfortable, and he would sleep in it and again if it was not so low.<br><br>The facility's Change in a Resident's Condition or Status policy dated 11/30/21, directed the facility to promptly notify the resident, the attending physician and the resident representative of changes in the resident's medical, mental condition and or status. | F 580 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed ensure residents were free from neglect for 1 of 3 residents (R1) reviewed for neglect.<br><br>Findings include: | F 600 | R1 had 2 call lights installed for use along with a recliner chair assessment, a new incontinence evaluation along with a recliner chair assessment was completed. R1 care plan was reviewed and updated as needed. Existing resident incidents related to allegations of abuse/neglect | 3/29/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 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 |
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| F 600 | Continued From page 6<br>R1's Face Sheet printed 3/10/22, indicated R1's diagnoses included heart failure, dementia without behavior disturbance, osteoarthritis, depression and a history of COVID-19.<br><br>R1's significant change Minimum Data Set (MDS) dated 2/5/22, indicated R1 needed limited assistance from staff with bed mobility and transfers. R1 needed extensive assistance from staff with dressing, hygiene and toilet use. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's weight was 275 pounds.<br><br>An incident report dated 2/26/22, at 5:29 p.m. indicated R1 reported to registered nurse (RN)-B on 2/25/22, staff had assisted him into the recliner. R1 reported he was stuck all night and felt "trapped." R1 also reported he was wet all night and he was unable to call for assistance because his call light was across the room. The facility took action by notifying the RN case manager (RN-A), and RN-B placed a sign on R1's door which indicated to make sure that the call light was within reach. The report indicated RN-B talked with the day shift nursing assistants (NA) and verified R1 was in the recliner at the start of their shift. The incident further indicated on 3/3/22, the interdisciplinary team (IDT) reviewed the incident report. The staff were educated to assure the call light was within reach at all times. A second call light would be obtained for use when R1 was in the recliner.<br><br>On 3/9/22, at 9:45 a.m. R1 was observed in his room sitting in the wheelchair in front of the television. The call light was tied to the transfer bar on R1's bed, and another call light was laying on the floor behind R1. A sign was posted on the | F 600 | from survey exit until present were reviewed and thoroughly investigated for root cause. Future resident will remain free from incidents of neglect per facility policy.<br>Nursing and IDT team was in-serviced on the Abuse Clinical Protocol Policy with focus on the definition of abuse which includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.<br>Social Services and/or designee will be responsible for compliance.<br>Audits on abuse allegation identification and reporting will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure compliance.<br>Audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation.<br>Compliance: 3/29/2022 | |

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| F 600 | Continued From page 7 | F 600 | | |

back of R1's door which indicated, "Make sure call light is within reach." R1 was asked if he was able to use his call light. R1 was unable to find the call light nearest to him due to the call light being on the floor, but was able to move himself in the wheelchair over to the bed to use the call light. When asked about using the recliner to rest or sleep in, R1 stated he was 93 years old, a tall guy, and the recliner was too small and too low.

On 3/9/22, at 10:36 a.m. NA-A was interviewed and stated on the day shift, R1 needed assistance to transfer from a low position, and R1 was able to use the call light.

On 3/9/22, at 10:47 a.m. RN-E was interviewed and stated R1's incident report was discussed last week during the IDT meeting. RN-E stated the incident report indicated R1 had reported in the morning on Saturday 2/26/22, he had been in the recliner all night, his call light was across the room, and no one had checked on him. R1 stated he was wet and felt trapped.

On 3/9/22, at 11:01 a.m. RN-A was interviewed and stated she was the unit manager, and had worked at the facility for about six months. RN-A stated R1 had developed COVID-19, was short of breath, unable to lay flat and lying in bed with the head of the bed elevated was not comfortable, so R1 was provided a recliner. RN-A stated on the night of 2/25/22, R1 was put in the recliner and stayed in recliner for the night. The next morning, 2/26/22, R1 reported he wanted to get out of recliner, no one had checked on him and his call light was not in reach. R1's complaint was discussed during the IDT meeting, and R1 was provided a call light for the recliner and the bed. RN-A stated she was horrified staff did not go in

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| F 600 | Continued From page 8 | F 600 | | |

and check on him during the night. RN-A stated she was working the morning of 2/26/22, and stated she felt R1 had been neglected.

On 3/9/22, at 1:26 p.m. the DON was interviewed and stated R1 was left in the recliner all night from 2/25/22, through the morning of 2/26/22, and was without his call light. The DON stated R1 told RN-B the morning of 2/26/22. RN-B completed the incident report on 2/26/22, at 5:29 p.m. The DON stated she would expect residents to be checked on every two to three hours. The DON stated she did not know if R1 had been checked on during the night. The DON stated she was not informed of the incident until the Monday morning meeting on 2/28/22. The DON stated the facility had cameras in the hallways, but she had not reviewed any of the tape to see if anyone had gone into R1's room during the night.

On 3/9/22, at 2:37 p.m. RN-B stated she has worked at the facility since 10/21, and usually worked the day shift. R1 reported the incident to her on 2/26/22, between 7:00 a.m. and 9:30 a.m. RN-B stated R1 was on precautions because of COVID-19, therefore, the door to his room was kept closed. RN-B stated R1 was upset, mad, and said he should report this place or staff. R1 reported to RN-B he was stuck in the recliner chair all night. RN-B verified with the NAs R1 was in the recliner at the start of the shift. The NAs did not confirm if R1 was wet or not. RN-B stated she was the first staff R1 told. RN-B reported R1's complaint to RN-A in person that afternoon. RN-B told next shift nurse in report to make sure they do quality checks, to ensure he was dressed, dry, and had the call light. In addition, RN-B stated she would usually notify the DON, but she had not.

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On 3/9/22, at 2:24 p.m. NA-B was interviewed and stated she had worked on the unit R1 resided on the night shift starting on 2/25/22. NA-B stated she worked the unit with a nurse and a float NA. NA-B stated she did a round at approximately 11:00 p.m. to 12:00 a.m. for the residents who needed to be checked and changed. NA-B stated if a resident was independent with toilet use, she did not check on them and would only go into their room if they put the call light on. NA-B stated R1 was able to use the call light if he needed assistance to go to the bathroom, but he had not put his call light on. NA-B stated she did not check to see if R1 had his call light.

On 3/10/22, at 9:10 a.m. a follow-up interview was conducted with R1. R1 was observed in his room bent forward in the wheelchair sleeping. R1 stated he was awake until midnight, had slept in his wheelchair, and had not slept well. R1 stated he could not sleep in the bed because when he laid down he had difficulty with phlegm coming up and he coughed uncontrollably. R1 further stated he could not sleep in the recliner in his room because it was too low, and he could not get out of it without help. R1 stated he was six foot one, his knees were above the arms of the recliner and he felt trapped in the recliner. R1 stated the recliner was comfortable, and he would sleep in it and again if it was not so low.

The facility's Routine Resident Checks policy dated 2/4/22, directed staff shall make routine resident checks to maintain the safety and well being of the resident at least once per eight hour shift. Routine checks involved entering the resident's room to determine if the resident's needs are being met, identify any changes in the

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| F 600 | Continued From page 10<br>resident's condition, identify any concerns and see if the resident needs any toileting assistance etc.<br><br>The facility's Abuse Prevention policy 2022, defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Other indicators of neglect included inability to access medical or nursing personnel when necessary. | F 600 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 3/8/22, through 3/10/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure.<br><br>The following complaint was found to be | 2 000 | | |

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| 2 000 | Continued From page 1<br>UNSUBSTANTIATED: H5227165C (MN81279, MN80919).<br><br>The following complaint was found to be SUBSTANTIATED: H5227166C (MN81527), however, NO licensing orders were issued.<br><br>The following complaints were found to be SUBSTANTIATED: H5227164C (MN81557) with licensing orders issued at 4658.0085 A-E.<br>.<br>The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |
| 2 265 | MN Rule 4658.0085 Notification of Chg in Resident Health Status<br><br>A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:<br><br>A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; | 2 265 | | 3/29/22 |

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| 2 265 | Continued From page 2<br><br>B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;<br><br>C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;<br><br>D. a decision to transfer or discharge the resident from the nursing home; or<br><br>E. expected and unexpected resident deaths.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to notify family of allegations of neglect for 1 of 3 residents (R1) reviewed for notification of change.<br><br>Findings include:<br><br>R1's Face Sheet printed 3/10/22, indicated R1's diagnoses included heart failure, dementia without behavior disturbance, osteoarthritis, depression and a history of COVID-19.<br><br>R1's significant change Minimum Data Set (MDS) dated 2/5/22, indicated R1 needed limited assistance from staff with bed mobility and transfers. R1 needed extensive assistance from staff with dressing, hygiene and toilet use. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's weight was 275 pounds. | 2 265 | R1 family representative and MD was made aware of this incident and their response will be recorded in the resident electronic medical record. R1 had a risk management incident created and thoroughly investigated. R1 care plan was reviewed and updated as needed. From survey exit until present, existing resident incidents related to allegations of abuse were reviewed for family/MD notification. Missing notification was made as needed. Future resident incidents, the family and MD will be notified of abuse allegations and change in condition per policy. Nursing and IDT team was in-serviced on the Abuse/Investigation/Reporting Policy and Procedure with emphasis on item #1 in which the MD, Attending Physician, Family, State Agency and Ombudsman will be notified of alleged allegations. In | |

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| 2 265 | Continued From page 3<br><br>An incident report dated 2/26/22, at 5:29 p.m. indicated R1 reported to registered nurse (RN)-B on 2/25/22, staff had assisted him into the recliner. R1 reported he was stuck all night and felt "trapped". R1 also reported he was wet all night and he was unable to call for assistance because his call light was across the room. The facility took action by notifying the RN case manager (RN-A), and RN-B placed a sign on R1's door which indicated to make sure that the call light was within reach. The report indicated RN-B talked with the day shift nursing assistants (NA) and verified R1 was in the recliner at the start of their shift. The incident further indicated on 3/3/22, the interdisciplinary team (IDT) reviewed the incident report. The staff were educated to assure the call light was within reach at all times. A second call light would be obtained for use when R1 was in the recliner. The incident report lacked indication if the incident was reported to R1's family.<br><br>On 3/9/22, at 9:45 a.m. R1 was observed in his room sitting in the wheelchair in front of the television. The call light was tied to the transfer bar on R1's bed, and another call light was laying on the floor behind R1. A sign was posted on the back of R1's door which indicated, "Make sure call light is within reach." R1 was asked if he was able to use his call light. R1 was unable to find the call light nearest to him due to the call light being on the floor, but was able to move himself in the wheelchair over to the bed to use the call light. When asked about using the recliner to rest or sleep in, R1 stated he was 93 years old, a tall guy, and the recliner was too small and too low.<br><br>On 3/9/22, at 1:12 p.m. FM-A was interviewed. FM-A stated he had not been notified of the | 2 265 | addition, the IDT team was in-serviced on notifying the MD/NP and family on changes in resident condition.<br>Social Services and/or designee will be responsible for compliance.<br>Audits on abuse allegation notification and resident change in condition notification will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure compliance.<br>Audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation.<br>Compliance: 3/29/2022 | |

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incident where R1 had been left all night in the recliner without his call light, and had not been checked on all night by staff. FM-A stated R1 told him he could not sit in the recliner because the recliner was too low and he could not get out of it. FM-A stated he believed this incident was neglect, it was inexcusable and had better not happen again. FM-A stated he was angry the facility did not tell him.

On 3/9/22, at 1:26 p.m. the director of nursing (DON) was interviewed, and stated on the evening of 2/25/22, R1 was placed in the recliner, and ended up staying in the recliner all night long, without the call light, and without staff checking on him. The DON stated R1 had reported this to RN-B the morning of 2/26/22. The DON stated she was not informed of the incident until the Monday morning meeting on 2/28/22. The DON verified the incident report and the progress notes lacked indication if family member (FM)-A had been notified of the incident. The DON stated she would expect FM-A be notified.

On 3/9/22, at 2:37 p.m. RN-B stated she has worked at the facility since 10/21, and usually worked the day shift. R1 reported the incident to her on 2/26/22, between 7:00 a.m. and 9:30 a.m. RN-B stated R1 was on precautions because of COVID-19, therefore, the door to his room was kept closed. RN-B stated R1 was upset, mad, and said he should report this place or staff. R1 reported to RN-B he was stuck in the recliner chair all night. RN-B verified with the NAs R1 was in the recliner at the start of the shift. The NAs did not confirm if R1 was wet or not. RN-B stated she was the first staff R1 told. RN-B reported R1's complaint to RN-A in person that afternoon. RN-B told next shift nurse in report to make sure they do quality checks, to ensure he was dressed, dry,

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| 2 265 | Continued From page 5<br>and had the call light. In addition, RN-B stated she would usually notify the DON, but she had not.<br><br>On 3/10/22, at 9:10 a.m. a follow-up interview was conducted with R1. R1 was observed in his room bent forward in the wheelchair sleeping. R1 stated he was awake until midnight, had slept in his wheelchair, and had not slept well. R1 stated he could not sleep in the bed because when he laid down he had difficulty with phlegm coming up and he coughed uncontrollably. R1 further stated he could not sleep in the recliner in his room because it was too low, and he could not get out of it without help. R1 stated he was six foot one, his knees were above the arms of the recliner and he felt trapped in the recliner. R1 stated the recliner was comfortable, and he would sleep in it and again if it was not so low.<br><br>The facility's Change in a Resident's Condition or Status policy dated 11/30/21, directed the facility to promptly notify the resident, the attending physician and the resident representative of changes in the resident's medical, mental condition and or status.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures regarding notification of change of condition.<br>The DON or designee could educate all appropriate staff on the policies and procedure on notification of change of condition.<br>The DON or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 265 | | |

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