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

DEPARTMENT OF HEALTH

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June 22, 2022

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

Re: Reinspection Results
Event ID: OG9J12

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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Electronically delivered

April 26, 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 21, 2022, we informed you that we may impose enforcement remedies.

On April 15, 2022, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY (delete if not IJ)

On April 14, 2022, the situation of immediate jeopardy to potential health and safety cited at F760 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 11, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 11, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 11, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department continues to recommend that CMS impose a civil money penalty, (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayshore Residence & Rehab Ctr is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 15, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division 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 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 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 September 10, 2022 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

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.

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, Compliance Analyst
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 04/15/2022

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 On 4/11/22, through 4/15/22, 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. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F760 began on 3/24/22, when registered nurse (RN)-A inadvertently discontinued R1's torsemide (diuretic). On 4/4/22, R1 was sent to the emergency department (ED) with low oxygen saturation levels (68% on room air) and difficulty breathing. R1 was admitted to the hospital and was given intravenous (IV) Lasix (diuretic). The administrator and director of nursing (DON) were notified of the IJ on 4/13/22, at 2:30 p.m. The IJ was removed on 4/14/22, at 12:42 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 4/14/22. The following complaints were found to be SUBSTANTIATED: H5227170C (MN82411), with a deficiency cited at F760. The following complaints were found to be UNSUBSTANTIATED: H5227169C (MN82377) H5227171C (MN82530) H5227172C (MN82655) 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/2022

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

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F 000	Continued From page 1 correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a system to ensure medications were correctly transcribed for 1 of 3 residents (R1). This resulted in an Immediate Jeopardy (IJ) situation for R1 when her torsemide (diuretic) was inadvertently discontinued which resulted in R1 not receiving diuretic medication for 11 days, and subsequently hospitalized with heart failure. The immediate jeopardy began on 3/24/22, when R1's torsemide had been incorrectly discontinued. On 4/4/22, R1 was sent to the emergency department (ED) with low oxygen saturation levels (68% on room air) and difficulty breathing. R1 was admitted to the hospital and was given intravenous (IV) Lasix (diuretic). Upon investigation, it was discovered R1's torsemide was incorrectly discontinued on 3/24/22. The administrator and the director of nursing (DON) were notified of the immediate jeopardy at 2:30 p.m. on 4/13/22. The IJ was removed on 4/14/22, at 3:30 p.m. but scope and severity remained at a level D, no actual harm with potential for more than minimal harm. Findings include:	F 760	R 1 did not return to the facility. All existing residents from survey exit until present were reviewed and all medications prescribed have current physician orders. Future residents will have MD ordered medications given as ordered and discontinued per facility policy. Nursing staff was in-serviced on the Medication and Treatment Order Policy and procedure with emphasis on transcribing verbal orders directly into the resident order tab in the resident electronic medical record and the How to Process the Order facility guideline with focus on placing the nurse initials and date from the nurse confirming that the order has been reviewed and processed. Director of Nursing and/or designee is responsible for compliance. Audits on resident medications with current physician orders and processing of physician orders will begin 2x week for 2 weeks, weekly x 1 week, monthly x3 months to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will present audit results to QAPI for review	5/9/22

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F 760	Continued From page 2 R1's Face Sheet printed on 4/11/22, indicated R1's diagnoses included congestive heart failure (CHF), essential hypertension and chronic obstructive pulmonary disease (COPD). R1's admission Minimum Data Set (MDS) dated 3/14/22, indicated R1 was cognitively intact. R1 required assistance of staff with hygiene, dressing and transfers, bed mobility, locomotion and toilet use. R1's Order Recap Report from 3/1/22, through 4/30/22, included Demadex (torsemide) 40 milligrams (mg) by mouth two times a day for water pill. The report indicated R1's torsemide was ordered and started on 3/8/22, and was discontinued with an end date on 3/24/22. A Physician/Prescriber Please Sign and Return form dated 3/24/22, indicated a voice order was received from nurse practitioner (NP)-B and signed by registered nurse (RN)-A. The order directed to discontinue the following supplements: bilberry capsule, milk thistle capsule, alpha lipoic acid capsule, evening primrose capsule, krill oil capsule, lactobacillus capsule, turmeric capsule, coenzyme Q10, and the cinnamon capsule. The order did not include to discontinue torsemide. A facility investigation indicated on 4/4/22, R1 was sent to the ED with difficulty breathing and low oxygen saturation levels of 68% on room air. Upon investigation, the facility discovered R1's torsemide had been discontinued on 3/24/22. Registered nurse (RN)-A had inadvertently discontinued R1's torsemide on 3/24/22, while discontinuing R1's supplements. The investigation indicated the transcription error was not caught until a medication review was	F 760	and recommendation. Compliance: 5/9/2022	

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F 760	Continued From page 3	F 760		

completed when R1 went to the ED on 4/4/22. R1 was admitted to the hospital and was given IV Lasix. RN-A was re-educated on the need to have all transcribed orders triple checked for accuracy and verbalized understanding. Medication order audits would also be occurring.

The ED to Hospital Admission report dated 4/4/22, indicated R1 was brought into the ED via ambulance. R1 suddenly became short of breath without chest pain that afternoon. While in the ED, R1 was noted to be wheezy and per the paramedics, R1's oxygen saturation was 60% while on room air. R1 was placed on BiPAP (a type of ventilator device that helps with breathing) and her oxygen saturation increased to 100%. R1 was somewhat hypertensive (elevated blood pressure) and continued to be tachycardic (a heart rate of over 100 beats per minute). A chest x-ray showed bilateral pulmonary edema (excess fluid in the lungs). R1 was admitted to the hospital. The report further indicated torsemide was not on R1's medication list from the facility. R1 improved significantly when given IV Lasix and was starting to diurese (excess fluid was removed from the body).

On 4/12/22, at 10:17 a.m. R1's family member (FM)-A was interviewed. FM-A stated there was nothing more the hospital could do for R1, and hospice care had been suggested.

On 4/12/22, at 10:56 a.m. R1's hospital physician (MD)-A was interviewed and stated R1 came into the hospital with heart failure and a knee infection. MD-A stated R1 had difficulty breathing and required IV Lasix. MD-A stated R1 had acute systolic heart failure, was hypoxic (low oxygen in the blood), and required an IV diuretic and

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F 760	Continued From page 4	F 760		

antibiotics. MD-A stated R1 not receiving the torsemide for 11 days could have contributed to her heart failure.

On 4/12/22, at 1:37 p.m. RN-A was interviewed and stated she received orders on 3/24/22, from the nurse practitioner (NP)-B to discontinue R1's vitamin supplements. RN-A stated there was a long list of supplements to discontinue. RN-A stated she went to R1's electronic medical record and discontinued the supplements, and somehow discontinued the torsemide. RN-A stated she did not know how or have any reason as to why the torsemide was discontinued. RN-A stated she then put out R1's chart to have the transcription double checked. RN-A stated the person who double checked the order would only check to make sure the supplements listed were discontinued, and the order was completed. RN-A stated she made a mistake resulting in R1 having to go to the hospital and she felt "pretty sick" about it.

On 4/12/22, at 2:58 p.m. the director of nursing (DON) was interviewed and stated discontinuing the torsemide was an error on RN-A's part. The DON stated RN-A was re-educated on how to process orders. The DON stated when the second and third checks were done, the person doing the checks was only able to see the medications that were ordered to be discontinued, were discontinued. The DON stated there was no way to see if a medication that had not been ordered to be discontinued, had been discontinued.

On 4/13/22, at 11:42 a.m. R1's cardiac nurse practitioner (NP)-A was interviewed. NP-A stated she had been following R1 in the hospital. NP-A

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F 760	Continued From page 5	F 760		

stated R1 was admitted to the hospital with both an acute episode of CHF, and elevated troponin levels. NP-A stated the elevated troponin levels indicated R1 may have also had a non-ST-elevation myocardial infarction (NSTEMI) heart attack. NP-A stated R1 had chest pain, and this indicated she had heart blockage. NP-A stated not receiving the torsemide would not have had anything to do with heart blockage. NP-A stated not getting the torsemide put R1 into heart failure. NP-A stated CHF is caused by a fluid overload, and the torsemide would have helped keep fluid off of R1's heart. NP-A stated not receiving the torsemide put R1 at risk for death.

The facility's How to Process an Order policy undated, directed to enter the order into the electronic record as accurately as possible. Place a check mark and initials on the paper copy after every order. Place the order in the second box for the floor nurse to double check. The nurse manager for the unit would then complete a triple check of the order. The order would then be placed in a fourth box on the unit for medical records to collect for shredding or long term storage.

The IJ was removed on 4/14/22, after the Medication Order policy was reviewed by the facility's clinical leadership. The facility's How to Process an Order guidelines were revised to include direction to and how to check for discontinued medications in the electronic orders. All nurses, health unit coordinators (HUC), trained medication administrators (TMA) and medical records were re-educated on the Medication Order policy and the How to Process an Order guidelines. The facility reviewed all resident medication records from 3/24/22, to current to

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F 760	Continued From page 6 ensure all medications had corresponding physician orders and the order was accurate. This was verified through staff interview and document review.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 26, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: OG9J11

Dear Administrator:

The above facility was surveyed on April 11, 2022 through April 15, 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, Compliance Analyst
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
	00589	A. BUILDING: _____ B. WING _____	04/15/2022

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) COMPLETE DATE
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		5/9/22

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21545	Continued From page 1 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a system to ensure medications were correctly transcribed for 1 of 3 residents (R1). This resulted in an Immediate Jeopardy (IJ) situation for R1 when her torsemide (diuretic) was inadvertently discontinued which resulted in R1 not receiving diuretic medication for 11 days, and subsequently hospitalized with heart failure. The immediate jeopardy began on 3/24/22, when R1's torsemide had been incorrectly discontinued. On 4/4/22, R1 was sent to the emergency department (ED) with low oxygen saturation levels (68% on room air) and difficulty breathing. R1 was admitted to the hospital and was given intravenous (IV) Lasix (diuretic). Upon investigation, it was discovered R1's torsemide was incorrectly discontinued on 3/24/22. The administrator and the director of nursing (DON) were notified of the immediate jeopardy at 2:30 p.m. on 4/13/22. The IJ was removed on 4/14/22, at 3:30 p.m. but scope and severity remained at a level D, no actual harm with potential for more than minimal harm. Findings include: R1's Face Sheet printed on 4/11/22, indicated R1's diagnoses included congestive heart failure (CHF), essential hypertension and chronic obstructive pulmonary disease (COPD).	21545	R 1 did not return to the facility. All existing residents from survey exit until present were reviewed and all medications prescribed have current physician orders. Future residents will have MD ordered medications given as ordered and discontinued per facility policy. Nursing staff was in-serviced on the Medication and Treatment Order Policy and procedure with emphasis on transcribing verbal orders directly into the resident order tab in the resident electronic medical record and the How to Process the Order facility guideline with focus on placing the nurse initials and date from the nurse confirming that the order has been reviewed and processed. Director of Nursing and/or designee is responsible for compliance. Audits on resident medications with current physician orders and processing of physician orders will begin 2x week for 2 weeks, weekly x 1 week, monthly x3 months to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will present audit results to QAPI for review and recommendation. Compliance: 5/9/2022	

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21545	Continued From page 2 R1's admission Minimum Data Set (MDS) dated 3/14/22, indicated R1 was cognitively intact. R1 required assistance of staff with hygiene, dressing and transfers, bed mobility, locomotion and toilet use. R1's Order Recap Report from 3/1/22, through 4/30/22, included Demadex (torsemide) 40 milligrams (mg) by mouth two times a day for water pill. The report indicated R1's torsemide was ordered and started on 3/8/22, and was discontinued with an end date on 3/24/22. A Physician/Prescriber Please Sign and Return form dated 3/24/22, indicated a voice order was received from nurse practitioner (NP)-B and signed by registered nurse (RN)-A. The order directed to discontinue the following supplements: bilberry capsule, milk thistle capsule, alpha lipoic acid capsule, evening primrose capsule, krill oil capsule, lactobacillus capsule, turmeric capsule, coenzyme Q10, and the cinnamon capsule. The order did not include to discontinue torsemide. A facility investigation indicated on 4/4/22, R1 was sent to the ED with difficulty breathing and low oxygen saturation levels of 68% on room air. Upon investigation, the facility discovered R1's torsemide had been discontinued on 3/24/22. Registered nurse (RN)-A had inadvertently discontinued R1's torsemide on 3/24/22, while discontinuing R1's supplements. The investigation indicated the transcription error was not caught until a medication review was completed when R1 went to the ED on 4/4/22. R1 was admitted to the hospital and was given IV Lasix. RN-A was re-educated on the need to have all transcribed orders triple checked for accuracy and verbalized understanding. Medication order	21545		

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21545	Continued From page 3	21545		

audits would also be occurring.

The ED to Hospital Admission report dated 4/4/22, indicated R1 was brought into the ED via ambulance. R1 suddenly became short of breath without chest pain that afternoon. While in the ED, R1 was noted to be wheezy and per the paramedics, R1's oxygen saturation was 60% while on room air. R1 was placed on BiPAP (a type of ventilator device that helps with breathing) and her oxygen saturation increased to 100%. R1 was somewhat hypertensive (elevated blood pressure) and continued to be tachycardic (a heart rate of over 100 beats per minute). A chest x-ray showed bilateral pulmonary edema (excess fluid in the lungs). R1 was admitted to the hospital. The report further indicated torsemide was not on R1's medication list from the facility. R1 improved significantly when given IV Lasix and was starting to diurese (excess fluid was removed from the body).

On 4/12/22, at 10:17 a.m. R1's family member (FM)-A was interviewed. FM-A stated there was nothing more the hospital could do for R1, and hospice care had been suggested.

On 4/12/22, at 10:56 a.m. R1's hospital physician (MD)-A was interviewed and stated R1 came into the hospital with heart failure and a knee infection. MD-A stated R1 had difficulty breathing and required IV Lasix. MD-A stated R1 had acute systolic heart failure, was hypoxic (low oxygen in the blood), and required an IV diuretic and antibiotics. MD-A stated R1 not receiving the torsemide for 11 days could have contributed to her heart failure.

On 4/12/22, at 1:37 p.m. RN-A was interviewed and stated she received orders on 3/24/22, from

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21545	Continued From page 4	21545		

the nurse practitioner (NP)-B to discontinue R1's vitamin supplements. RN-A stated there was a long list of supplements to discontinue. RN-A stated she went to R1's electronic medical record and discontinued the supplements, and somehow discontinued the torsemide. RN-A stated she did not know how or have any reason as to why the torsemide was discontinued. RN-A stated she then put out R1's chart to have the transcription double checked. RN-A stated the person who double checked the order would only check to make sure the supplements listed were discontinued, and the order was completed. RN-A stated she made a mistake resulting in R1 having to go to the hospital and she felt "pretty sick" about it.

On 4/12/22, at 2:58 p.m. the director of nursing (DON) was interviewed and stated discontinuing the torsemide was an error on RN-A's part. The DON stated RN-A was re-educated on how to process orders. The DON stated when the second and third checks were done, the person doing the checks was only able to see the medications that were ordered to be discontinued, were discontinued. The DON stated there was no way to see if a medication that had not been ordered to be discontinued, had been discontinued.

On 4/13/22, at 11:42 a.m. R1's cardiac nurse practitioner (NP)-A was interviewed. NP-A stated she had been following R1 in the hospital. NP-A stated R1 was admitted to the hospital with both an acute episode of CHF, and elevated troponin levels. NP-A stated the elevated troponin levels indicated R1 may have also had a non-ST-elevation myocardial infarction (NSTEMI) heart attack. NP-A stated R1 had chest pain, and this indicated she had heart blockage. NP-A

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21545	Continued From page 5 stated not receiving the torsemide would not have had anything to do with heart blockage. NP-A stated not getting the torsemide put R1 into heart failure. NP-A stated CHF is caused by a fluid overload, and the torsemide would have helped keep fluid off of R1's heart. NP-A stated not receiving the torsemide put R1 at risk for death. The facility's How to Process an Order policy undated, directed to enter the order into the electronic record as accurately as possible. Place a check mark and initials on the paper copy after every order. Place the order in the second box for the floor nurse to double check. The nurse manager for the unit would then complete a triple check of the order. The order would then be placed in a fourth box on the unit for medical records to collect for shredding or long term storage. The IJ was removed on 4/14/22, after the Medication Order policy was reviewed by the facility's clinical leadership. The facility's How to Process an Order guidelines were revised to include direction to and how to check for discontinued medications in the electronic orders. All nurses, health unit coordinators (HUC), trained medication administrators (TMA) and medical records were re-educated on the Medication Order policy and the How to Process an Order guidelines. The facility reviewed all resident medication records from 3/24/22, to current to ensure all medications had corresponding physician orders and the order was accurate. This was verified through staff interview and document review. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and	21545		

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21545	Continued From page 6 procedures to ensure medication orders are transcribed accurately. 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.	21545		