



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 2, 2026

Administrator
BAYSHORE RESIDENCE AND REHABILITATION CENTER
1601 ST LOUIS AVENUE
DULUTH, MN 55802

RE:CCN:245227
Event ID: 3PNH11
Cycle Start Date: May 27, 2025

Dear Administrator

On May 27, 2025, a survey was completed at your facility by the Minnesota Department of Health to investigate a complaint 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. The investigation resulted in no deficiencies being issued.

At the time of the investigation, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction". This applies to federal deficiencies only. Electronically attached is your copy of the Federal Form CMS-2567 stating that no violations were noted at the time of this investigation.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245227 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/27/2025 |
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| NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE , DULUTH, Minnesota, 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 |
| F0000 | <p>INITIAL COMMENTS</p> <p>On 5/27/25, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed:</p> <p>H52274817C (MN 113046). NO deficiencies were cited.</p> <p>The facility is enrolled in ePOC, 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.</p> | F0000 | | |

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 reverse for further 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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00589 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/27/2025 |
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| NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE , DULUTH, Minnesota, 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 |
| 20000 | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 5/27/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaint was reviewed:</p> <p>H52274817C and MN 113046. NO licensing orders were issued.</p> | 20000 | | |

Office of Primary Care and Health Systems Management

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