Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 11, 2026

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

RE: CCN: 245227
Cycle Start Date: December 4, 2025

Dear Administrator:

On February 10, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

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December 4, 2025

Administrator
BAYSHORE RESIDENCE AND REHABILITATION CENTER

1601 ST LOUIS AVENUE
DULUTH, MN 55802

RE: CCN:245227
Cycle Start Date: December 4, 2025

Dear Administrator:

On December 4, 2025, a survey was completed at your facility by the Minnesota Departments of Health 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:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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 March 4, 2026, (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 June 4, 2026, (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

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

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

Re: Event ID: 1D9CDD-H1

Dear Administrator:

The above facility survey was completed on December 4, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. 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. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900
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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 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE AND REHABILITATION CENTER	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	INITIAL COMMENTS On 10/23/25 through 10/24/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H52276303C (2648533) with deficiencies issued at F50 and F627. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding	F0550	F 550 R 1 and R 2 have since been discharged from the facility. All current residents' leave of absence orders were removed. No further orders will be initiated upon admission. The interdisciplinary team (IDT) and Licensed Nurses will be in-serviced on the updated Leave of Absence Policy (12/13/2025) with emphasis on the policy statement that the residents can choose to leave the facility for limited periods of time for therapeutic reasons. Social Services and/or designee is responsible for compliance. Audits leave of absence order removal from resident order set will begin weekly x 2 weeks, monthly x 3 months to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation.	12/16/2025

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.

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

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

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F0550 SS = D	Continued from page 1 transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure residents right to leave the facility was honored for 2 for 3 residents (R1, R2) reviewed who had physicians orders restricting their rights to a leave of absence. R1's Admission Record indicated she admitted to the facility on 2/9/24. Diagnoses include type 2 diabetes mellites (DMII), infection of left hip, pain, weakness and gait abnormalities. R1's care plan dated 2/10/24, indicated she was at low risk for elopement. The care plan identified substance abuse/dependence as evidenced by resident having alcohol and drug paraphernalia/admitting to substance use and indicated leave of absence (LOA) privileges revoked per physician. R1's Physician Order Report dated 10/20/25, identified the following order dated 7/10/25: Revoked privileges of LOA. Resident not allowed to leave facility per provider. R2's Admission Record indicated he admitted to the facility 2/13/25. Diagnoses included: depression, head laceration, anemia, tobacco use and alcohol dependence. R2's care plan dated 9/4/25, indicated R2 had a history	F0550	Continued from page 1 Compliance: 12/16/2025	

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F0550 SS = D	Continued from page 2 of impaired decision making related to choices that put his health and safety at risk despite education and a risk for self-harm related to chemical dependency. The care plan further indicated LOA privileges revoked per provider. R2's Order Summary Report dated 9/2/25, identified the following order dated 8/7/25, indicated LOA suspended due to patient safety concerns. A written agreement between R2 and the administrator dated 8/26/25, indicated R2 "agrees to go to the bank and a couple of stores today." R2 promised he would not consume beer or alcohol of any kind while on his shopping trip today. R2 would be home by 5:00 p.m. This will be a one-time trip and will be reported to his physician. A written agreement between R2 and the administrator dated 8/29/25, indicated R2 "agrees to go to the bank and a couple of stores today." R2 promised he would not consume beer or alcohol of any kind while on his shopping trip today. R2 would leave facility after 9:00 a.m. and return before 2:00 p.m. This will be a one-time trip and will be reported to his physician. During interview on 10/23/25 at 2:01 p.m., social services designee (SSD)-A stated R1's LOA privileges were revoked because she was using drugs and alcohol. SSD-A said typically residents were allowed to leave the facility with family or friends and said the facility asked for information about leaving and returning. During interview on 10/23/25 at 2:07 p.m., the administrator stated R1 had an order from the physician to rescind her LOA status. The administrator stated the facility safety policy trumped the resident's rights. The administrator stated he suspected R1 had been bringing drugs and alcohol into the facility. The administrator said R2 had been doing unsafe things and was "warned" he would need to discontinue his behavior. After many violations, R2 had his LOA privileges revoked. The administrator said R2 had been allowed to walk around the facility grounds and the building. The administrator said R2 did well and had been set up with some trial leaves and then at one point he did not return to the facility and showed up at the hospital. During interview on 10/23/25 at 3:02 p.m., licensed social worker (LSW)-A stated R1 had gone on leaves from the facility and had not returned on time. LSW-A said they suspected R2 had been under the influence. LSW-S said the physician ordered urinalysis but R1 refused so	F0550		

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F0550 SS = D	Continued from page 3 the physician wrote an order that she could not leave the facility. LSW-A was asked if any less restrictive options were discussed prior to restricting R1's right to leave the facility and said she was not aware of any and had not been directly involved. LSW-A said according to facility policy, leaving the facility was a privilege, not a right and the privilege could be revoked. Facility policy Resident Leave of Absence/Pass privileges dated 5/10/22, indicated the facility recognizes the right of the residents for whom reside at this facility that it is their home and they can choose to leave the facility for limited periods for therapeutic reasons. The facility also recognizes the need of the residents to leave to prepare for discharge. It is not in the best interest of the residents to leave the facility, but it is encouraged to enjoy the facility grounds between times during the provision of medical care. Because the purpose of admission is to provide a continuum of care and treatment, the facility leave of absence policy may be granted in accordance with specific guidelines. Purpose: To clarify circumstances under which authorization for leaving the facility is needed. To establish guidelines regarding the right to return to the facility upon termination of an authorized pass. Procedure 1. Upon admission, resident wanting to leave the facility during the assessment period will only be allowed to leave with a responsible party. Demographic information, including purpose, will be required. The order will read, “Resident Ok for pass privileges with responsible party”. This order will automatically generate upon the resident arrival/admission to the facility. 2. Until the resident is fully assessed by both occupational therapy and the attending physician, the physician will deem that the resident is safe to leave the facility and will issue an order	F0550		

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F0550 SS = D	Continued from page 4 “Resident Ok for independent leave of absence pass privileges”. 3. The MD also has the authorization to not grant leave of absence pass privileges. Thus, the order will read “resident not ok for leave of absence pass privileges d/t……”. 4. Residents leaving the facility must sign the designated leave of absence pass IN/OUT form. This book/binder is located at each nurse’s station. The resident must complete the form which includes leaving time from facility, expected return time and purpose for pass. In addition, the staff nurse must initial that this form is complete. Those residents who require responsible party signatures will also be required to provide this information before leaving the facility. Failure to complete this process will result in pass privilege termination. 5. The resident and/or responsible party must alert facility staff (preferably the nurse) upon arrival back to the facility. 6. Medications that must be administered while the resident is out will be given to the resident/person signing the resident out. No narcotic medications will be issued. 7. Written and/or oral instructions on when and how to administer the medication will be provided to the resident or to the person signing the resident out. Only medications that must be administered while the resident is out will be issued. 8. Resident leave of absence/pass times is daily from 10:00 am to 9:00pm. These times may be adjusted per Administrator discretion, inclement weather, etc. Failure to Return	F0550		

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F0550 SS = D	Continued from page 5 Residents who have not returned by 9:00pm but by midnight, the following will occur: a. Responsible party/guardian will be called. b. If no response, 911 will be contacted. c. Pass privileges will be suspended pending IDT review.	F0550		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate.	F0627	R1 discharged from the facility on 10/20/2025. There are currently no residents with discharge plans currently. Future residents who discharge will have a Transfer Discharge notice presented prior to leaving the facility per facility policy. The Interdisciplinary Team and Licensed Nurses will be in-serviced on the Discharging the Resident Policy, that indicate the resident and/or representative must be consulted before the transfer occurs, Preparing the Resident for Discharge Policy that indicates that a post discharge plan will be developed prior to his or her discharge and must be reviewed 24 hours prior to discharge and on the Transfer Discharge Notice Policy that indicates residents who have planned discharges will have the Discharge Notice completed for all impending discharges from the facility indicating the reason for the transfer will be documented in the resident chart. Social Services and/or designee is responsible for compliance. Audits on resident/resident representative notice of pending discharge, post discharge plan meeting and Transfer Notice issuance prior to discharge will begin weekly x 2 weeks, monthly x 3 months to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 12/16/2025	12/16/2025

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F0627 SS = D	Continued from page 6 §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	F0627		

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F0627 SS = D	Continued from page 7 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.	F0627		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0627 SS = D	Continued from page 8 (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record,	F0627		

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F0627 SS = D	Continued from page 9 the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure appropriate discharge rights for 1 of 3 residents (R1) who was discharged from the facility following a leave of absence. R1's Admission Record indicated she admitted to the facility on 2/9/24. Diagnosis include DMII, infection of left hip, pain, weakness and gait abnormalities. R1's care plan dated 2/10/24 indicated she was at low risk for elopement. The care plan identified substance abuse/dependence as evidenced by resident having alcohol and drug paraphernalia/admitting to substance use and indicated leave of absence (LOA) privileges revoked per physician. R1's Physician Order Report dated 10/20/25, identified the following order dated 7/10/25: Revoked privileges of LOA. Resident not allowed to leave facility per provider. R1's Resident Discharge Summary indicated she discharged from the facility 10/20/25. the summary identified R1's discharge location as other and indicated, unable to meet her needs.	F0627		

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F0627 SS = D	Continued from page 10 R1's Progress Notes indicated the following: 10/20/25 at 5:33 p.m., R1 left the facility on an LOA, against medical advice (AMA), despite having LOA privileges revoked per physician order. R1 departed the facility with her family. Both R1 and her family were aware privileges had been revoked. Per facility policy and physicians order, leaving the facility under these circumstances was considered leaving AMA. R1 later contacted the facility by phone and was informed she violated the revoked LOA order and was officially considered to have left AMA. R1 was advised she could come back to the facility and collect her belongings. 10/20/25. 6:18 p.m., R1 and family member came to the facility to grab R1's coat, writer and nurse went to the car to have R1 sign AMA form. R1 refused to sign the form, arguing the facility was stealing her wheelchair which belonged to the facility. R1 educated if she refused to sign the form, staff would sign with a witness. Writer went to get signature from R1's daughter and R1 repeatedly told her daughter not to sign the form. Daughter said she would sign the form the next morning when they came to get the rest of R1's belongings. AMA form was signed by writer and nurse. 10/21/25, 9:47 a.m., Writer asked R1's daughter to sign AMA paperwork as she stated she would the previous night. Daughter stated she was not signing anything. During interview on 10/23/25 at 1:40 p.m., registered nurse (RN)-A stated she believed R1 was currently with her daughter. RN-A said R1 had previously had her LOA privileges revoked because she had tested positive for drugs and brought alcohol back to the facility. RN-A stated R1 had gone out the previous month and had been re-educated. RN-A said the previous Monday, R1 left the facility without telling staff and the administrator told staff to proceed with the AMA due to not following the physician order and said when R1 called she told her since she broke the policy, she was considered discharged AMA and family could pack her belongings. RN-A said R1 had every intention of coming back to the facility but the administrator said she could not. During interview on 10/23/25 at 2:01 p.m., social services designee (SSD)-A stated R1's LOA privileges were revoked because she was using drugs and alcohol. SSD-A said typically residents were allowed to leave the facility with family or friends and said the facility asked for information about leaving and returning.	F0627		

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F0627 SS = D	Continued from page 11 During interview on 10/23/25 at 2:07 p.m., the administrator stated R1 had an order from the physician to rescind her LOA status. The administrator stated he suspected R1 had been bringing drugs and alcohol into the facility and providing them to other residents. The administrator said there were many discussions with the physicians about why R1 could not leave the facility and indicated the decision was for R1's safety. The administrator said RN-A had reported to him, R1 had left the facility and he told RN-A to follow the AMA procedure. During interview on 10/23/25 at 3:49 p.m., the director of nursing (DON) stated the facility did not have any evidence R1 was giving drugs or alcohol to other residents, only suspicion. During interview on 10/23/25 at 3:02 p.m., licensed social worker (LSW)-A stated R1 had gone on leaves from the facility and had not returned on time. LSW-A said they suspected R1 had been under the influence. LSW-S said the physician ordered urinalysis but R1 refused so the physician wrote an order that she could not leave the facility. During interview on 10/23/25 at 4:53 p.m., the administrator stated R1 did well when she was sober and family was able to visit and he felt it was healthier for R1 to remain at the facility and not go on LOA. Facility policy Transfer or Discharge Notice dated 7/22/16, indicated: Except as specified below, a resident, and/or his or her representative (sponsor) will be given a thirty (30)-day advance notice of an impending transfer or discharge from our facility and a bed hold notice given to the resident and/or representative for emergent transfers or therapeutic leave: a. The transfer is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility. b. The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility. c. The safety of individuals in the facility is endangered.	F0627		

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F0627 SS = D	Continued from page 12 d. The health of individuals in the facility would otherwise be endangered. e. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. f. An immediate transfer or discharge is required by the resident's urgent medical needs. g. The resident has not resided in the facility for thirty (30) days; and/or h. The facility ceases to operate.	F0627		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/23/25 through 10/24/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaint was reviewed during the survey. H52276303C (2648533). Minnesota Department of Health is documenting the State	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 Licensing Correction Orders using Federal software. 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.	20000		