DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2023

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

RE: CCN: 245227
Cycle Start Date: March 9, 2023

Dear Administrator:

On March 24, 2023, we notified you a remedy was imposed. On April 11, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 28, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 8, 2023 did not go into effect. (42 CFR 488.417 (b))

As we notified you in our letter of March 24, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 9, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 3, 2023

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

Re: Reinspection Results
Event ID: FMDA12

Dear Administrator:

On April 11, 2023 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 March 9, 2023. 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
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 24, 2023

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

RE: CCN: 245227
Cycle Start Date: March 9, 2023

Dear Administrator:

On March 9, 2023, survey was completed at your facility by the Minnesota Department 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.

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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 9, 2023, the situation of immediate jeopardy to potential health and safety cited at F600 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 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 April 8, 2023.

This Department is also recommending 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 8, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 8, 2023, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 9, 2023. This prohibition is not subject to appeal. 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.

If you have not achieved substantial compliance by April 8, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bayshore Residence & Rehab Ctr will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 8, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at

§488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require 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 Sections 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 March 9, 2023. 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 plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 9, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 DENIAL OF PAYMENT

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	C 03/09/2023

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 3/7/23 to 3/9/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52279075C (MN00091621), H52279075C (MN00091615), H52279116C (MN00091585), and H52279116C (MN00091592). Deficiencies were issued at F600. The immediate jeopardy began on 2/17/23, when family member (FM)-A reported to registered nurse (RN)-C R2 and R3 were found in R1's room. R3 was sitting on top of R1's legs, in her bed, pulling her pants down. The immediate jeopardy was removed on 3/9/23. The above findings constituted substandard quality of care, and an extended survey was conducted. As a result of the investigation, additional deficiencies were cited at F609,and F610. 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.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		3/28/23

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

Electronically Signed | 03/29/2023

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 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to protect a resident from sexual abuse and failed to implement protective measures to prevent ongoing abuse for 1 of 1 resident (R1) reviewed for abuse. This deficient practice resulted in an immediate jeopardy (IJ) when R3 was discovered sitting on top of R1 in the bed and pulling her pants down while R2 was standing next to the bed with their pants down below their knees. Further, the facility failed to implement protective measures, assess for ability to consent, and notify R1's physician of the incident. The IJ began on 2/17/23, when family member (FM)-A reported to registered nurse (RN)-C R1's R2 and R3 were found in R1's room. R3 was sitting on top of R1's legs, in her bed, pulling her pants down. R2 was standing next to R1's bed. The regional director of operations for Minnesota (RDO) and director of nursing (DON) were notified of the IJ for R1 on 3/8/23, at 2:21 p.m.	F 600	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□ s allegation of compliance in accordance with section 7305 of the State Operations Manual. F 600 R1 has since discharged from the facility. R2 and R3 were both on 15-minute checks throughout the remainder of R1 discharge from the facility. R2 and R3□s	

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F 600	Continued From page 2 The IJ was removed on 3/9/23, at 2:39 p.m. when the facility successfully implemented a removal plan; however, non-compliance remained at an isolated scope of potential for more than minimal harm (Level D). Findings include: R2's annual Minimum Data Set (MDS) dated 1/26/23, indicated a BIMS (brief interview for mental status) of 3, severe cognitive impairment and lacked evidence of any behaviors. R2's care plan 3/7/23, indicated potential for aggressive physical/verbal behaviors toward other related to severe cognitive impairment. R2's progress notes lack any evidence of physical or verbal behaviors toward other residents on 2/17/23. R3's significant change MDS dated 1/16/23, indicated a BIMS of 00, severe cognitive impairment and lacked evidence of any behaviors. R3's care plan 3/7/23, lacked any evidence of aggressive behavior or issue with relating to other resident. R3's progress note dated 2/17/23, at 9:21 p.m. indicated R3 had behaviors this shift. He followed a female resident into her room and attempted to assist her remove her pajama pants. Both residents [R2 and R3] were taking their shoes and started to take off their clothing when nursing assistant intervened. R1's admission MDS dated 2/20/23, indicated a	F 600	vulnerable adult care plan was reviewed and updated as needed. All other residents/resident representatives in the facility were interviewed and reported feeling safe while in the facility. For future admissions into the memory care unit, family members will review the facility secured unit policy and will also be presented with information regarding dementia and intimacy. Preferences will be recorded in the resident vulnerable adult care plan. Facility staff were in-serviced on the on Abuse, Abuse Reporting, and Identifying Sexual Abuse Capacity Consent Policy with emphasis on item # 5 of the sexual abuse capacity policy that the facility will investigate and protect a resident when there may be a resident who does not have the capacity to consent. Administrator and Director of Nursing is responsible for compliance. Audits on vulnerable adult care planning and capacity to consent along with admission education will begin weekly x 4 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and further recommendations. Compliance: 3/28/2023	

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F 600	Continued From page 3 BIMS of 00, severe cognitive impairment. R1 was independent for activities of daily living (ADLs) with set up and cues. Diagnoses included Alzheimer's disease and dementia. R1's care area assessment (CAA) indicated cognitive loss/dementia and behavioral symptoms were special need areas the facility would need to address. R1's care plan dated 2/13/23, indicated R1 had severely impaired cognitive function and impaired thought process. Interventions included cue, re-orient and supervise. The care plan also indicated R1 would be kept safe and free from abuse. R1's care plan lacked interventions to protect R1 from R2 or R3. During an interview on 3/7/23, at 10:58 a.m. FM-A stated: -On 2/17/23, FM-A came to visit. His wife's door was closed. He walked into R1's room and found R3 sitting on top of R1 with his buttocks on R1's ankles. R3 had R1's knees between R3's knees. R3 was actively pulling R1's jeans down. However, R1 had pajama pants on under the jeans. R2 was standing next to R1's bed. FM-A stated R1 started wearing jeans over her pajamas after she moved into the facility. FM-A stated he reported immediately R3 sitting on R1's ankle to the registered nurse (RN)-C on duty. -On 2/18/23, R3 had "barged" into R1's room, stopped and exited room when R3 realized FM-A was visiting. FM-A stated he reported this to RN-C -On 3/2/23, FM-A visited in the evening. R1 was asleep when he entered the room. FM-A woke R1. She sat up and pointed to a parka on the bedside table with R2's name in it. FM-A reported the parka to the RN-B immediately.	F 600		

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F 600	Continued From page 4 -FM-A stated since 2/17/23, R1 cried and could not say why. On several occasions R1 had pointed to R2 and R3 and said "they are bad men", she didn't like them. R1 was not able to explain why she felt this way. R1's progress note dated 2/17/23, at 8:29 p.m. indicated husband, family member (FM-A) reported concerns about an issue with a male resident who was following R1 in the halls and was found in R1's room removing R1's pajama pants. He states two male residents have exhibited this behavior toward his wife. Per nursing assistant (NA) R1 and R3 were removing both of their clothing and shoes. R1 and R3 were separated by staff and became upset. Nurse manager was notified. Staff to continue to monitor. However, R1's chart lacked evidence R1 was assessed for safety/injury, notification of provider, whether R3 was on top of R1's ankles, or if R2 was found in R1's room as reported by FM-A. R1's progress note dated 3/3/23, at 12:44 p.m. indicated FM-A had found R2's coat on R1's bedside table in her room. R1's Social Service-Resident Vulnerability and Susceptibility to Abuse-V3 form dated 2/20/23, at 3:22 p.m. indicated R1 was at risk for abuse related to cognitive impairment and physical impairment. R1 was also a vulnerable adult unable to report concerns related to abuse. Progress noted dated 2/20/23, at 3:11 p.m. social worker (SW) attempted to complete a PHQ-9 (mood assessment). Resident (R1) has been noted to have a couple tearful episodes. R1 was unable to state what made her upset.	F 600		

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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
F 600	Continued From page 5 On 3/7/23, at 10:43 a.m. R3 was observed entering R1's room and then closed the door behind him. He left R1's room approximately 1 minute later. R1 was not in her room. During an interview on 3/7/23, at 11:43 a.m. RN-A stated on 2/17/23, she was notified of an incident which involved R1 and R3. Both residents were found in R1's room with their clothes partially off. RN-A talked with the staff and R1. She notified the director of nursing (DON). RN-A stated she had not talked with any of the other residents to see if they felt safe. The facility started R1 and R3 on 15-minute checks that ended at 8:00 a.m. on 2/20/23. RN-A reviewed the 15-minute check logs from 2/17/23 through 2/20/23. She confirmed R1 and R3's logs lacked documentation 15-minute checks were completed from 2:15 p.m. to 9:45 p.m. on 2/18/23. RN-A stated she was not aware R3 had reentered R1's room on 2/18/23. RN-A stated R3 could have re-entered R1's room and staff would not have been aware of it since 15-minute checks were not documented which indicated they had not been completed. RN-A stated after 2/20/23, there were no interventions in place to keep R1 safe from R3. RN-A stated R1, R2 and R3 were on a locked memory care unit and residents wandered into other resident rooms. Residents undressing other residents was normal behavior the facility was not worried about. During an interview on 3/7/23, at 12:26 p.m. nurse assistant (NA)-C stated R3 attempted to go into R1's room at least twice a day. She was not working on 2/17/23, but was aware that R1, R2 and R3 were on 15-minute checks from 2/17/23 to 2/20/23. After 2/20/23, there had been no	F 600		

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F 600	Continued From page 6 interventions to keep R1, R2 and R3 separated. Staff were "watching" them and R1, R2, R3 were allowed to do, and gather like all other residents. NA-C stated residents were never allowed to assist other residents get undressed. Since the residents on the memory care unit were confused, acts such as sexual assault could happen if they help each other get undressed, especially since they would not know or be able to give consent related to their dementia. On 3/7/23, at 12:13 p.m. phone call to RN-C. Message was left to return call. During an interview on 3/7/23, at 12:58 p.m. the certified nurse practitioner (CNP)-A stated she had not been made aware of the incident on 2/17/23, involving R1, R2 and R3 and she should have been notified when the incident occurred. The facility should have followed their sexual assault/abuse protocol since the residents were found partially undressed and were unable to make decision themselves about being unclothed together. During an interview on 3/7/23, at 1:14 p.m. NA-E stated R3 had told her "several times" R1 was his girlfriend. NA-E saw R1 and R3 walking around the unit holding hands and standing close to each other a few times. She attempted to separate them but R3 would get mad and say R1 was his girlfriend. During an interview on 3/7/23, at 1:27 p.m. registered nurse (RN)-B stated on 3/3/23, FM-A brought a parka out of R1's room that had R2's name written on it. She confirmed the parka belonged to R2 and returned to R2. RN-B stated she did not know how the parka eneded up in	F 600		

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F 600	Continued From page 7 R1's room because R2 would always wear the parka everywhere and would not let it out of his site. During an interview on 3/7/23, at 1:42 pm licensed social worker (LSW)-A stated when a resident-to-resident altercation occurred she talked with the resident, provided supportive measures for mental health and if needed worked with nursing orders for mental health providers to evaluate the residents affected. She was part of the interdisciplinary team (IDT) and resident to resident altercations would be discussed during meetings. She was aware of the concerns related to R1, R2 and R3 but had not checked on R1 to see how her mental health was since the incident on 2/17/23. LSW-A stated the IDT had never discussed R1, R2 and R3's incident in one of their meetings to see how to keep R1 safe from R2 or R3. During an interview on 3/7/23, at 2:26 p.m. NA-A stated she witnessed the incident on 2/17/23. R1 and R3 were in R1's room by her bed with their pants down below their knees. They were actively pulling up their jeans when she entered the room. NA-A stated R1 had a pair of pajamas on under her jeans that were still pulled up. R3's underwear was exposed, and R2 was sitting in the chair next to the bed. During an interview on 3/7/23, at 2:36 p.m. NA-B stated she witnessed the incident on 2/17/23, R1 and R3 were in R1's room by her bed with their pants down below their knees. They were actively pulling up their jeans when he entered the room. NA-B stated R1 had a pair of pajamas on under her jeans that were still pulled up, R3's underwear was exposed, and R2 was sitting in the chair next	F 600		

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F 600	Continued From page 8 to the bed. During an interview on 3/7/23, at 1:52 p.m. the director of nursing (DON) stated she had been notified R1, R2 and R3 were in R1's room with clothes partially removed. She discussed it with the administrator. DON did not talk with any other staff or residents to see if there were concerns related to R3 or if the residents felt safe in the facility. DON stated residents in a memory care help other residents get undressed. "We did not see it as sexual abuse" because R1 did not make an accusation of abuse and "nobody witnessed anything happened" other than that two residents had their pants partially off. "Just because the residents both had their pants off did not make it sexual abuse." All residents involved had severe cognitive impairment and were unable to consent to having their clothes removed by another resident. The facility did not place any interventions to keep R1 safe from R2 and R3 because "we did not feel it was sexual abuse". During an interview on 3/7/23, at 3:16 p.m. the administrator stated the only investigation done was to get a statement from the NAs who worked 2/17/23 on the memory care unit and the nurse manager. Since nobody witnessed anything and R1 reported nothing happened, it did not need to be reported. Nor did the facility need to protect R1 from R2 and R3. On 3/8/23, at 8:33 a.m. and 10: 43 a.m. phone calls placed to RN-C. Messages left to return call. RN-C never returned phone call. Facility policy, Bayshore Residence and Rehabilitation Center Abuse Prevention 2023 indicated the policy was to provide a safe living	F 600		

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F 600	Continued From page 9 environment to all residents of the facility. The policy also indicated residents, the alleged perpetrator, and other staff would be protected from harm during an investigation. The policy lacked information about protecting the residents after the investigation. The IJ which began on 2/17/23, was removed on 3/9/23, when the facility had assessed all residents for safety, educated all staff on the abuse policy and assessed R1 for any abnormal findings.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		3/28/23

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F 609	Continued From page 10 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report to the state agency (SA) resident to resident abuse (R3 towards R1) for 1 of 1 resident to resident allegations reviewed. Findings include: R1's admission Minimum Data Set (MDS) dated 2/20/23, indicated R1 had severely impaired cognition, and was independent for activities of daily living (ADLs) with set up and cues. Diagnoses included Alzheimer's disease and dementia. R1's care area assessment (CAA) indicated cognitive loss/dementia and behavioral symptoms were special need areas the facility would need to address. R1's care plan dated 2/13/23, indicated R1 had impaired cognitive function and impaired thought process. Interventions included cue, re-orient and supervise. The care plan also indicated R1 would be kept safe and free from abuse. R1's progress notes dated 2/17/23, at 8:29 p.m. indicated husband reported concerns about an issue with a male resident who was following R1 in the halls and had been found in R1's room removing R1's pajama pants. The progress note also indicated per nursing assistant (NA) had entered R1's room and found R1 and R3 removing both of their clothing and shoes. R1 and R3 were separated. Staff and the nurse manager	F 609	F 609 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□ s allegation of compliance in accordance with section 7305 of the State Operations Manual. R1 incident was reported to the state agency on 3/8/2023. All other facility incidents from survey exit were reviewed and were reported timely to the state agency. Future allegation of abuse will be reported per facility abuse reporting policy guidelines. Facility staff were in-serviced on the on the Abuse Reporting policy with emphasis on item #3 that incidents will be reported immediately but no later than 2hrs of an allegation of abuse. Administrator and Director of Nursing is responsible for compliance.	

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F 609	Continued From page 11 were notified. During an interview on 3/7/23, at 10:58 a.m. family member (FM)-A stated on 2/17/23, he walked into R1's room and found R3 sitting on top of R 1 with his buttocks on R1's ankles and R3 had R1's knees between R3's knees. R3 was actively pulling R1's jeans down, but she had pajama pants on under them. FM-A stated R1 had been wearing jeans over her pajamas since moving into the facility. R2 was standing next to R1's bed. "I reported it right away to the nurse working". During an interview on 3/7/23, at 2:26 p.m. nurse assistant (NA)-A stated R1 and R3 were in R1's room with their pants down below their knees and actively pulling them up when she entered. NA-A stated she seperated the residents, removed R3 from R1's room and notified the nurse in charge. During an interview on 3/7/23, at 11:43 a.m. registered nurse (RN)-A stated on 2/17/23 she was notified of an incident that involved R1 and R3. Both residents were found in R1's room with their clothes partially off. She talked with the staff, R1, and notified the director of nursing (DON). RN-1 stated either the DON or the administrator were responsible to report the concern to the state agency (SA). During an interview on 3/17/23, at 1:52 p.m. the DON stated she had been notified R1 and R3 were in R1's room with clothes partially removed and discussed it with the administrator. The decision was made that there was no concern to report to the SA. The DON stated it occurred on a memory care unit and "this kind of stuff happens all the time" with dementia residents. The facility	F 609	Audits on reporting timely to the state agency will begin weekly x 4 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and further recommendations. Compliance: 3/28/2023	

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F 609	Continued From page 12 only reported concerns related to sexual abuse when there was an allegation of abuse or it was witnessed. During an interview on 3/17/23, at 3:16 p.m. the administrator stated he did not report the concern to the SA because there was "nothing to report". Facility policy Bayshore Residence and Rehabilitation Center Abuse Prevention 2023, indicated all resident to resident incidents, unless isolated must be reported to the SA. Sexual abuse included, but was not limited to, sexual harassment, sexual coercion or sexual assault. Sexual assault included any sexual activity that occurs when an individual cannot or does not consent.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		3/28/23

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F 610	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential abuse were thoroughly investigated for 1 of 3 residents (R1) who had an allegation of abuse. Findings include: R1's admission Minimum Data Set (MDS) dated 2/20/23, indicated R1 had severely impaired cognition, and was independent for activities of daily living (ADLs) with set up and cues. Diagnoses included Alzheimer's disease and dementia. R1's care area assessment (CAA) indicated cognitive loss/dementia and behavioral symptoms were special need areas the facility would need to address. R1's care plan dated 2/13/23, indicated R1 had impaired cognitive function and impaired thought process. Interventions included cue, re-orient and supervise. The care plan also indicated R1 would be kept safe and free from abuse. R1's progress notes dated 2/17/23, at 8:29 p.m. indicated husband reported concerns about an issue with a male resident who was following R1 in the halls and had been found in R1's room removing R1's pajama pants. The progress note also indicated two nursing assistants (NA) had entered R1's room and found R1 and R3 removing both of their clothing and shoes. R1 and R3 were separated. Staff and the nurse manager were notified. During an interview on 3/7/23, at 10:58 a.m. family member (FM)-A stated on 2/17/23, he walked into R1's room and found R3 sitting on top	F 610	F 610 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. R1 incident was reported to the state agency on 3/8/2023. All other incidents from survey exit until present were thoroughly investigated and root cause identified. Future incidents will be reported to the state agency timely per facility abuse reporting policy. Facility staff were in-serviced on the Abuse Reporting and Investigation policy with emphasis on the investigation section item #7 that incidents will include interviewing staff from all shifts, review of the clinical documentation and any witnesses to determine root cause and complete thorough investigation of the incident. Administrator and Director of Nursing is responsible for compliance. Audits on thorough review of incidents will	

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F 610	Continued From page 14 of R 1 with his buttocks on R1's ankles and R3 had R1's knees between R3's knees. R3 was actively pulling R1's jeans down, but she had pajama pants on under them. FM-A stated R1 had been wearing jeans over her pajamas since moving into the facility. R2 was standing next to R1's bed. "I reported it right away to the nurse working". During an interview on 3/7/23, at 2:26 p.m. nurse assistant (NA)-A stated R1 and R3 were in R1's room with their pants down below their knees and actively pulling them up when I entered. NA-A seperated R1 and R3, removed R3 from R1's room and reported to the nurse in charge. During an interview on 3/7/23, at 11:43 a.m. registered nurse (RN)-A stated on 2/17/23 she was notified of an incident that involved R1 and R3. Both residents were found in R1's room with their clothes partially off. She talked with the staff, R1, and notified the director of nursing (DON). "I did not talk with any of the other residents to see if they felt safe". During an interview on 3/17/23, at 1:52 p.m. the DON stated she had been notified R1 and R3 were in R1's room with clothes partially removed and discussed it with the administrator. She did not talk with any other staff or other residents to see if there were any other concerns related to R3 or if the residents felt safe in the facility. During an interview on 3/17/23, at 3:16 p.m. the administrator stated the investigation included interviews with the NA's and the nurse manager. No further investigations was completed. Facility policy, Bayshore Residence and	F 610	begin weekly x 4 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and further recommendations.	

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F 610	Continued From page 15 Rehabilitation Center Abuse Prevention 2023, indicated all incidences such as falls, bruises, medication errors, resident complaints, etc would be investigated by the facility.	F 610		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 24, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: FMDA11

Dear Administrator:

The above facility was surveyed on March 7, 2023 through March 9, 2023 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
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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 _____	C 03/09/2023

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/7/23 to 3/9/23, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were reviewed during the survey: H52279075C(MN00091621), H52279075C (MN00091615), H52279116C (MN00091585), H52279116C (MN00091592) . 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 445	MN Rule 4658.0220 Freedom from Corporal Punishment & Seclusion A resident must be free from corporal punishment and involuntary seclusion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to protect a resident from sexual abuse and failed to implement protective measures to prevent ongoing abuse for 1 of 1 resident (R1) reviewed for abuse. This deficient practice resulted in an immediate jeopardy (IJ) when R3 was discovered sitting on top of R1 in the bed and pulling her pants down while R2 was standing next to the bed with their pants down below their knees. Further, the facility failed to implement protective measures, assess for ability to consent, and notify R1's physician of the incident. Findings include: R2's annual Minimum Data Set (MDS) dated 1/26/23, indicated a BIMS (brief interview for mental status) of 3, severe cognitive impairment and lacked evidence of any behaviors. R2's care plan 3/7/23, indicated potential for aggressive physical/verbal behaviors toward	2 445	Corrected	3/28/23

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2 445	Continued From page 3 other related to severe cognitive impairment. R2's progress notes lack any evidence of physical or verbal behaviors toward other residents on 2/17/23. R3's significant change MDS dated 1/16/23, indicated a BIMS of 00, severe cognitive impairment and lacked evidence of any behaviors. R3's care plan 3/7/23, lacked any evidence of aggressive behavior or issue with relating to other resident. R3's progress note dated 2/17/23, at 9:21 p.m. indicated R3 had behaviors this shift. He followed a female resident into her room and attempted to assist her remove her pajama pants. Both residents [R2 and R3] were taking their shoes and started to take off their clothing when nursing assistant intervened. R1's admission MDS dated 2/20/23, indicated a BIMS of 00, severe cognitive impairment. R1 was independent for activities of daily living (ADLs) with set up and cues. Diagnoses included Alzheimer's disease and dementia. R1's care area assessment (CAA) indicated cognitive loss/dementia and behavioral symptoms were special need areas the facility would need to address. R1's care plan dated 2/13/23, indicated R1 had severely impaired cognitive function and impaired thought process. Interventions included cue, re-orient and supervise. The care plan also indicated R1 would be kept safe and free from abuse. R1's care plan lacked interventions to protect R1 from R2 or R3.	2 445		

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2 445	Continued From page 4 During an interview on 3/7/23, at 10:58 a.m. FM-A stated: -On 2/17/23, he walked into R1's room and found R3 sitting on top of R1 with his buttocks on R1's ankles. R3 had R1's knees between R3's knees. R3 was actively pulling R1's jeans down. However, R1 had pajama pants on under the jeans. R2 was standing next to R1's bed. FM-A stated R1 started wearing jeans over her pajamas after she moved into the facility. FM-A stated he reported immediately R3 sitting on R1's ankle to the registered nurse (RN)-C on duty. -On 2/18/23, R3 had "barged" into R1's room, stopped and exited room when R3 realized FM-A was visiting. FM-A stated he reported this to RN-C -On 3/2/23, FM-A visited in the evening. R1 was asleep when he entered the room. FM-A woke R1. She sat up and pointed to a parka on the bedside table with R2's name in it. FM-A reported the parka to the RN-B immediately. -FM-A stated since 2/17/23, R1 cried and could not say why. On several occasions R1 had pointed to R2 and R3 and said "they are bad men", she didn't like them. R1 was not able to explain why she felt this way. R1's progress note dated 2/17/23, at 8:29 p.m. indicated husband, family member (FM-A) reported concerns about an issue with a male resident who was following R1 in the halls and was found in R1's room removing R1's pajama pants. He states two male residents have exhibited this behavior toward his wife. Per nursing assistant (NA) R1 and R3 were removing both of their clothing and shoes. R1 and R3 were separated by staff and became upset. Nurse manager was notified. Staff to continue to monitor. However, R1's chart lacked evidence R1	2 445		

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2 445	Continued From page 5 was assessed for safety/injury, notification of provider, whether R3 was on top of R1's ankles, or if R2 was found in R1's room as reported by FM-A. R1's progress note dated 3/3/23, at 12:44 p.m. indicated FM-A had found R2's coat on R1's bedside table in her room. R1's Social Service-Resident Vulnerability and Susceptibility to Abuse-V3 form dated 2/20/23, at 3:22 p.m. indicated R1 was at risk for abuse related to cognitive impairment and physical impairment. R1 was also a vulnerable adult unable to report concerns related to abuse. Progress noted dated 2/20/23, at 3:11 p.m. social worker (SW) attempted to complete a PHQ-9 (mood assessment). Resident (R1) has been noted to have a couple tearful episodes. R1 was unable to state what made her upset. On 3/7/23, at 10:43 a.m. R3 was observed entering R1's room and then closed the door behind him. He left R1's room approximately 1 minute later. R1 was not in her room. During an interview on 3/7/23, at 11:43 a.m. RN-A stated on 2/17/23, she was notified of an incident which involved R1 and R3. Both residents were found in R1's room with their clothes partially off. RN-A talked with the staff and R1. She notified the director of nursing (DON). RN-A stated she had not talked with any of the other residents to see if they felt safe. The facility started R1 and R3 on 15-minute checks that ended at 8:00 a.m. on 2/20/23. RN-A reviewed the 15-minute check logs from 2/17/23 through 2/20/23. She confirmed R1 and R3's logs lacked documentation 15-minute checks were completed from 2:15 p.m. to 9:45	2 445		

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2 445	Continued From page 6 p.m. on 2/18/23. RN-A stated she was not aware R3 had reentered R1's room on 2/18/23. RN-A stated R3 could have re-entered R1's room and staff would not have been aware of it since 15-minute checks were not documented which indicated they had not been completed. RN-A stated after 2/20/23, there were no interventions in place to keep R1 safe from R3. RN-A stated R1, R2 and R3 were on a locked memory care unit and residents wandered into other resident rooms. Residents undressing other residents was normal behavior the facility was not worried about. During an interview on 3/7/23, at 12:26 p.m. nurse assistant (NA)-C stated R3 attempted to go into R1's room at least twice a day. She was not working on 2/17/23, but was aware that R1, R2 and R3 were on 15-minute checks from 2/17/23 to 2/20/23. After 2/20/23, there had been no interventions to keep R1, R2 and R3 separated. Staff were "watching" them and R1, R2, R3 were allowed to do, and gather like all other residents. NA-C stated residents were never allowed to assist other residents get undressed. Since the residents on the memory care unit were confused, acts such as sexual assault could happen if they help each other get undressed, especially since they would not know or be able to give consent related to their dementia. On 3/7/23, at 12:13 p.m. phone call to RN-C. Message was left to return call. During an interview on 3/7/23, at 12:58 p.m. the certified nurse practitioner (CNP)-A stated she had not been made aware of the incident on 2/17/23, involving R1, R2 and R3 and she should have been notified when the incident occurred. The facility should have followed their sexual	2 445		

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2 445	Continued From page 7 assault/abuse protocol since the residents were found partially undressed and were unable to make decision themselves about being unclothed together. During an interview on 3/7/23, at 1:14 p.m. NA-E stated R3 had told her "several times" R1 was his girlfriend. NA-E saw R1 and R3 walking around the unit holding hands and standing close to each other a few times. She attempted to separate them but R3 would get mad and say R1 was his girlfriend. During an interview on 3/7/23, at 1:27 p.m. registered nurse (RN)-B stated on 3/3/23, FM-A brought a parka out of R1's room that had R2's name written on it. She confirmed the parka belonged to R2 and returned to R2. RN-B stated she did not know how the parka eneded up in R1's room because R2 would always wear the parka everywhere and would not let it out of his site. During an interview on 3/7/23, at 1:42 pm licensed social worker (LSW)-A stated when a resident-to-resident altercation occurred she talked with the resident, provided supportive measures for mental health and if needed worked with nursing orders for mental health providers to evaluate the residents affected. She was part of the interdisciplinary team (IDT) and resident to resident altercations would be discussed during meetings. She was aware of the concerns related to R1, R2 and R3 but had not checked on R1 to see how her mental health was since the incident on 2/17/23. LSW-A stated the IDT had never discussed R1, R2 and R3's incident in one of their meetings to see how to keep R1 safe from R2 or R3.	2 445		

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2 445	Continued From page 8 During an interview on 3/7/23, at 2:26 p.m. NA-A stated she witnessed the incident on 2/17/23. R1 and R3 were in R1's room by her bed with their pants down below their knees. They were actively pulling up their jeans when she entered the room. NA-A stated R1 had a pair of pajamas on under her jeans that were still pulled up. R3's underwear was exposed, and R2 was sitting in the chair next to the bed. During an interview on 3/7/23, at 2:36 p.m. NA-B stated she witnessed the incident on 2/17/23, R1 and R3 were in R1's room by her bed with their pants down below their knees. They were actively pulling up their jeans when he entered the room. NA-B stated R1 had a pair of pajamas on under her jeans that were still pulled up, R3's underwear was exposed, and R2 was sitting in the chair next to the bed. During an interview on 3/7/23, at 1:52 p.m. the director of nursing (DON) stated she had been notified R1, R2 and R3 were in R1's room with clothes partially removed. She discussed it with the administrator. DON did not talk with any other staff or residents to see if there were concerns related to R3 or if the residents felt safe in the facility. DON stated residents in a memory care help other residents get undressed. "We did not see it as sexual abuse" because R1 did not make an accusation of abuse and "nobody witnessed anything happened" other than that two residents had their pants partially off. "Just because the residents both had their pants off did not make it sexual abuse." All residents involved had severe cognitive impairment and were unable to consent to having their clothes removed by another resident. The facility did not place any interventions to keep R1 safe from R2 and R3 because "we did not feel it was sexual abuse".	2 445		

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2 445	Continued From page 9 During an interview on 3/7/23, at 3:16 p.m. the administrator stated the only investigation done was to get a statement from the NAs who worked 2/17/23 on the memory care unit and the nurse manager. Since nobody witnessed anything and R1 reported nothing happened, it did not need to be reported. Nor did the facility need to protect R1 from R2 and R3. On 3/8/23, at 8:33 a.m. and 10: 43 a.m. phone calls placed to RN-C. Messages left to return call. RN-C never returned phone call. Facility policy, Bayshore Residence and Rehabilitation Center Abuse Prevention 2023 indicated the policy was to provide a safe living environment to all residents of the facility. The policy also indicated residents, the alleged perpetrator, and other staff would be protected from harm during an investigation. The policy lacked information about protecting the residents after the investigation. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents on a locked unit for safety from other residents, review abuse/neglect policy and procedure with all staff and conduct random audits. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 445		