DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4K0A

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00589

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245227**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1821433426**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE RESIDENCE & REHAB CTR**
(L4) **1601 ST LOUIS AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2013**

6. DATE OF SURVEY **12/17/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **139** (L18)
13.Total Certified Beds **139** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	139			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date:
Deb Vincent, HFE NE II — 12/17/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske, Enforcement Specialist — 12/17/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/22/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 17, 2018

Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, MN 55802

RE: Project Number S5227030

Dear Administrator:

On November 9, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on October 26, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 10, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 10, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2018, effective December 10, 2018 and therefore remedies outlined in our letter to you dated November 9, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697

An equal opportunity employer.

Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245227

December 17, 2018

Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, MN 55802

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 10, 2018 the above facility is certified for:

139 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 139 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4K0A

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00589

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245227**
2.STATE VENDOR OR MEDICAID NO.
(L2) **1821433426**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE RESIDENCE & REHAB CTR**
(L4) **1601 ST LOUIS AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2013**
6. DATE OF SURVEY **10/26/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **139** (L18)
13.Total Certified Beds **139** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	139			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date:
Kimberly Settergren, HFE NE II — 11/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 12/03/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/22/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 9, 2018

Administrator
Bayshore Residence & Rehabilitation Center
1601 St. Louis Avenue
Duluth, MN 55802

RE: Project Numbers S5227030, H5227078, H5227079

Dear Administrator:

On October 26, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the October 26, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint numbers H5227078, H5227079 that were found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 5, 2018.

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.

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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 January 26, 2019 (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 April 26, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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 10/26/2018

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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/22/18, to 10/26/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the emergency preparedness plan was communicated to residents' family and/or responsible party. Findings include: The facility emergency preparedness plan reviewed 9/17/18, lacked a plan for communication of the emergency preparedness plan to residents' family and/or responsible party. On 10/25/18, at 4:10 p.m. the administrator verified the emergency preparedness plan had	E 035	Corrective Action: A. Resident Council was notified the facility has an emergency preparedness plan and the steps of the plan during the 11/8/18 Resident Council meeting. Corrective Action as it applies to other Residents: A. A letter was drafted and sent to all residents and/or responsible party's on 11/16/18 notifying them the facility has an emergency preparedness plan along with pertinent information. Recurrence will be prevented by:	12/10/18

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

Electronically Signed | 11/15/2018

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.

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 10/26/2018

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
E 035	Continued From page 1 not been communicated to residents' families and/ or responsible party, and the plan lacked a procedure for doing so.	E 035	A. Emergency preparedness plan will be reviewed annually and updated as needed. B. All staff educated on the findings of E035 and the corrective action the facility will make. Education was provided in several small group meetings and 1:1 education. Person responsible: Administrator	
F 000	INITIAL COMMENTS A recertification survey was conducted 10/22/18, to 10/26/18, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaints #H5227078 and #H5227079 were completed and were found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561		12/10/18

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 10/26/2018

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 561	Continued From page 2 through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure morning cares were provided at the preferred time for 1 of 3 residents (R29) reviewed for choices. Findings include: R29's quarterly Minimum Data Set (MDS) dated 8/1/18, indicated R29 was cognitively intact, had a diagnosis of paraplegia, and required extensive assistance from staff with bed mobility, transfers,	F 561	Corrective Action: A. Unit Nurse Manager met with R29 11/13/18 to discuss a plan to meet care needs according to R29's preferences. B. Social Services will meet with R29 every other week for two months to assure resident can make choices. C. Interdisciplinary team will offer to meet with R29 quarterly at his care conference to assure he can make choices.	

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 10/26/2018

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 561	Continued From page 3 personal hygiene, and dressing. R29's Physician's Orders dated 10/23/18, directed staff to provide wound care twice daily, every day and evening shift. On 10/22/18, at 4:03 p.m. R29 was interviewed and stated he was not able to receive morning cares and be out of bed by his preferred time of 10:00 a.m. R29 stated about once a week staff did not have him up until a few minutes before lunch at noon. On 10/24/18 at 9:45 a.m. registered nurse (RN)-A entered R29's room and provided wound cares. R29 was still in pajamas and had not been washed up yet. R29 explained that he often waited for a nurse to come do his wound care before he got up in the morning, and that was a major factor to the delay in getting him up by his preferred time. RN-A explained that she knew R29 wanted to get out of bed earlier, and would prefer he had wound care and was out of bed earlier, but there were other residents with heavy care needs on the unit, such as tube feedings, respiratory cares, blood sugars and time sensitive medications that she needed to prioritize. When asked if R29 would be ok getting morning cares and getting out of bed prior to receiving wound cares, R29 explained he would not be comfortable with that due to the nature of his wounds and wound care needs. RN-A agreed, stating, "That would not make any sense" because the dressings were wet and soiled prior to her providing wound care in the morning. RN-A stated R29 was frequently not getting wound cares and morning cares in time for him to be out of bed by his preferred time of	F 561	Corrective Action as it applies to other Residents: A. All residents were interviewed to assure they can make self-determination. Recurrence will be prevented by: A. All staff educated on the findings of F561 and the corrective action the facility will make. Education was provided in several small group meetings and 1:1 education. B. Audits to assure self-determination rights will occur 4x's per week for 3 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Person responsible: Director of Social Services	

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 10/26/2018

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 561	Continued From page 4 10:00 a.m. RN-A finished providing wound care for R29 at 10:32 a.m. RN-A said she would let the nursing assistants know they could provide morning cares for R29. On 10/25/18, at 12:28 p.m. nursing assistant (NA)-D stated R29's unit was very busy, and there were many residents with heavy care needs. NA-D stated this contributed to R29 waiting for the nurse to provide wound care. NA-D stated the NAs waited until after the nurse provided wound care to R29 to provide morning cares, and get him out of bed. NA-D reported sometimes R29 got frustrated and refused cares due to waiting. On 10/25/18, at 3:54 p.m. RN-G stated she was not aware of R29's concern about not getting up at his preferred time. RN-G reported the unit was very busy due to residents with heavy care needs and having very specific preferences. The facility's Resident Rights policy dated 1/4/18, directed federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to participate in decisions and care planning.	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		12/10/18

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 10/26/2018

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 584	Continued From page 5 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure housekeeping services provided a clean environment for 1 of 1 residents (R9) who room had unkept tube feeding equipment. In addition, the facility failed to maintain water temperatures within acceptable levels on 1 of 8 units (100 unit) on which	F 584	Corrective Action: A. R9's tube feeding pump and IV pole was cleaned 10/24/18. Scheduled review/cleaning has been entered in the TAR for weekly cleaning and daily check. B. Boiler adjustment made 11/5/18. C. Maintenance performs water	

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 10/26/2018

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 584	Continued From page 6 residents complained of water being too cold. Findings include: During the initial facility tour on 10/22/18, at 5:14 p.m. it was observed in R9's room the resident care equipment was soiled. R9's tube feeding pump was coated in dried tan feeding solution. The IV (intravenous) pole (from the feeding pump to the wheeled base) was also coated with dried tan feeding solution. Above the feeding pump there was large quantity of paper tape wrapped around the IV pole, also coated with feeding solution. During the environmental tour on 10/24/18, at 2:52 p.m. the maintenance director (MD) and the administrator both verified the entire enteral feeding set up (pump and IV pole) were soiled and should have been cleaned. The facility policy Cleaning and Disinfection of Resident-Care Items and Equipment dated 1/4/18, directed only what cleaning products were to be used, which depended on manufacturer's instructions. No further information was provided. During a resident interview on 10/23/18, at 3:20 p.m. R118 stated the bathroom water was always cold. On 10/23/18, at 3:32 p.m. R99 stated the water in the bathroom never got hot. R99 stated he received a daily bed bath, and it was upsetting his cares were performed with cold water. Both R9 and R118 resided on the facility's 100	F 584	temperature checks five days per week, twice per day to monitor water temperatures. D. Maintenance will maintain and record temperatures. E. Adjustments to the boiler will be made as needed. Corrective Action as it applies to other Residents: A. Facility identified two additional tube feeding pumps and IV poles in use and assured they were scheduled for daily checks and weekly cleaning. B. Facility reviewed and revised 'Cleaning and Disinfection of Resident Care Items and Equipment.' C. Facility reviewed 'Water Temps' policy. Recurrence will be prevented by: A. All LPN's and RN's were educated on the findings of F584 and the expectation to maintain clean tube feeding pumps and IV poles. Education was provided in several small group meetings and 1:1 education. B. All staff were educated on water temperatures and how to report inadequate temperatures. C. Audits of IV poles will occur 4x's per week for 3 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Person responsible: Director of Nursing	

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 10/26/2018

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 584	Continued From page 7 unit. During the environmental tour on 10/24/18, at 2:44 p.m., the maintenance director (MD) and the administrator took water temperatures in both rooms, obtaining only 88-89 degrees Fahrenheit (F) after the water had ran for 5 minutes. Both MD and the administrator stated about a month ago during a boiler inspection, they noted a 110 F temperature, receiving a recommendation to turn the boiler temperature down for resident safety. MD stated the facility had two boilers and a hot water holding tank, which were located on the facility's roof, in an enclosed structure. MD stated now that the weather was getting colder, the settings may have to be readjusted. MD and the administrator both stated the facility takes daily temperatures in random locations throughout the facility. On 10/25/18, at 7:10 a.m. the administrator provided further information that MD adjusted the boiler setting twice yesterday (10/24/18), and finally achieved 111 F on the unit where these two rooms were located. However, on 10/25/18, at 7:19 a.m. during a follow up water temperature check with MD and the administrator the water was let to run in a random room on the 100 unit. After 3 minutes the temperature was 103 F, and after 5 minutes 108 F was obtained. In review of the facility's water temperature logs (7/09/18, through 10/25/18), water temperatures were recorded to be between 94.0 - 106.7 F for at least 1 of the 2 rooms randomly checked on 35 days by the facility.	F 584	and Maintenance Director	

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 10/26/2018

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 584	Continued From page 8 The facility policy Water Temperatures, Safety Of dated of 1/4/18, directed water heaters/boilers that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of not more than 120 F, or the maximum allowable temperature per state regulation. The policy further directed maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		12/10/18

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 10/26/2018

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 585	Continued From page 9	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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 10/26/2018

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 585	Continued From page 10 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up on a written grievance for 1 of 2 residents (R29) reviewed for grievances. Findings include: R29's quarterly Minimum Data Set (MDS) dated	F 585	Corrective Action: A. Facility reviewed and updated the 'Transfer Room to Room' policy to include involuntary room move notice appeal process and factors for room moves. B. Social Services will meet with R29 every other week for two months to assure resident offers no grievances.	

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 10/26/2018

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 585	Continued From page 11 8/1/18, indicated R29 was cognitively intact and had a diagnosis of paraplegia. Review of a room change notice, dated 7/16/18, indicated, "This letter is to notify you that in seven days will be moved to room [room number] Reason: you will be moved from a double room to a private room." The form further directed, "You have a right to contest this action, you may do so with the Social Service Department or the Nursing Department. You are also free to contact the Long Term Care Ombudsman" R29 signed and wrote a response "I wish to stay in my room [room number] I'd like to be taken care of same staff I have for over 2 1/2 years and see my doctor about my continued care here. I understand that I will have a roommate if I remain on [unit]." On 10/22/18, at 4:03 p.m. R29 reported he was moved from a different room and unit about eight months ago. R29 stated, "I was a lot happier [on the other unit]" and added it was quieter, staff treated him better and it did not take so long to get a call light answered on his previous unit. R29 stated, "I was just baffled and all they said was 'we're just protecting you because you'll have a private room.' I had two or three different roommates while I was [on the other unit] but for the most part I had the room to myself." On 10/24/18, at 2:14 p.m. registered nurse (RN)-A stated she had questioned why R29 was moved to his current unit, explaining that there were a lot of residents with heavy care needs. RN-A stated R29 had complained he felt ignored. On 10/25/18, at 8:29 a.m. the director of social	F 585	C. Interdisciplinary team will offer to meet with R29 quarterly at his care conference to assure he can make choices. Corrective Action as it applies to other Residents: A. All residents were provided with a copy of the 'Grievance/Concern Policy' B. Facility reviewed how to file a concern/grievance at 11/8/18 at Resident Council Meeting. C. 'How to file a resident concern/grievance' will be presented at resident council meetings quarterly for one year. Recurrence will be prevented by: A. Administrator or designee will follow-up within one week with each resident served an involuntary room move notice. B. All staff will be educated on how to file a concern/grievance and where the concern/grievance forms are located. C. Audits to assure residents and staff are familiar with grievance/concern process will occur 4x's per week for 3 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Person responsible: Administrator	

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 10/26/2018

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 585	Continued From page 12	F 585		

service (SW)-A stated R29 was moved to his current unit due to his age and problems with previous roommates. SW-A stated she would look into how the facility addressed R29's concerns.
On 10/25/18, at 2:55 p.m. SW-A and SW-B stated the facility was only required to provide a seven day notice of room change, and the facility was not required to follow up with R29's concern related to the room change. SW-B stated she told R29 to contact the ombudsman (resident advocate employed by the state) if he wanted to appeal the move. SW-A and SW-B both verified there was no documentation of follow up related to R29's concern regarding the room change.

Review of a word document signed by SW-B undated, indicated SW-B was aware R29 wanted to stay in his room. SW-B told R29 he would get a roommate if did not move. SW-B documented she instructed R29 he needed to contact the ombudsman if he did not want to move.

A review of a word document signed by the administrator dated 10/26/18, indicated the administrator wrote he was made aware of R29 not wanting to move rooms. The administrator wrote that he instructed R29 to contact the ombudsman, and R29 may need to go before an administrative law judge to appeal the move. The administrator documented he explained to R29 the benefits of having his own room.

The facility Resident Concern policy revised 1/7/17, directed staff that residents or their representatives wishing to register a concern may request to see any employee of Bayshore Residence and Rehabilitation. The resident may

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 10/26/2018

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 585	Continued From page 13 request the assistance of an advocate. The concern may be written or presented orally. If written, a concern form will be reported to [state agency] if suspected or reported maltreatment is noted by the complainant. Oral grievances will be handled in the same manner immediately. The policy further directed all concerns will be immediately submitted to the charge nurse on duty and followed up. Information will be gathered regarding the concern and an assessment of the situation will be made by the facility. All concerns will be investigated per facility protocol. All concerns will be logged by social services into internal concern logs and trended for any patterns. All patterns will be reviewed at QA [quality assurance] meeting. All originals will be maintained by social service director. The policy further directed acknowledgement of receipt of the concern with notification to DON [director of nursing], social worker and administrator. Interview with resident or representative to clarify nature of complaint. All complainants will be notified of a resolution. All concerns will be resolved within 30 days, and a notification letter provided to the complainant, except in extenuating circumstances that have been explained to, and are acceptable to the complainant.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum	F 641	Corrective Action: A. Section N was changed 10/24/18 in	12/10/18

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 10/26/2018

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 641	Continued From page 14 Data Set (MDS) for 1 of 5 residents (R68) reviewed for unnecessary medication. Findings include: R68's quarterly MDS dated 8/28/18, indicated R68 received an anticoagulant medication three times and did not receive insulin during the look back period for the assessment reference date (ARD) of 8/28/18. R68's Medication Review Report printed 10/25/18, included orders for Coumadin (an anticoagulant) 5 milligram (mg) 5 days a week, and 7.5 mg 2 days a week. The report also included orders for Insulin Detemir Solution Pen-injector 40 units subcutaneously two times a day, and NovoLOG Solution (Insulin Aspart) 8 units subcutaneously three times a day. R68's August 2018, electronic Medication Administration Record (eMAR) indicated R68 did receive anticoagulant medication seven times and received insulin injections seven times between 8/22/18-8/28/18. However, the MDS indicated R68 received anticoagulant medication three times and did not receive insulin injections during the 7-day look back. On 10/23/18, at 4:14 p.m. registered nurse (RN)-E verified R68's MDS indicated R68 received anticoagulant medication three times and no insulin injections during the period ending 8/28/18. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 "Enter in item N0350A, the number of	F 641	R68's MDS to accurately state seven doses of anticoagulation and insulin were received. Corrective Action as it applies to other Residents: A. All MDS's were reviewed to assure section N is accurate in all residents. Recurrence will be prevented by: A. All staff educated on the findings of F561 and the corrective action the facility will make. Education was provided in several small group meetings and 1:1 education. B. Second check audits to assure accuracy with MDS will be completed with every MDS for one month and at least fifty percent of all MDS completed for three months after the first month will be audited to assure accuracy. Person responsible: MDS Coordinator	

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 10/26/2018

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 641	Continued From page 15 days during the 7-days look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received." "Record the number days an anticoagulant medications was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure cleaning and trimming of nails to maintain cleanliness and grooming for 1 of 2 residents (R2, R23) reviewed for activities of daily living (ADLs). Findings include: R2's Admission Record printed 10/26/18, indicated R2's diagnoses included dementia, muscle weakness, and cerebral infarction (stroke). R2's quarterly Minimum Data Set (MDS) dated 7/23/18, indicated R2 had a mild cognitive impairment, did not reject cares, and required extensive assistance of one staff for grooming. R2's care plan revised 4/19/18, directed staff to provide extensive assistance of one staff for personal hygiene.	F 677	Corrective Action: A. R23, R2 and R32's finger nails were cleaned and trimmed by 11/14/18. B. Shower sheet has been updated to assure nails are checked and addressed by staff. Corrective Action as it applies to other Residents: A. All residents were observed by 11/16/18 to assure clean and trimmed nails. Recurrence will be prevented by: A. All staff educated on the findings of F677 and the corrective action the facility will make. Education was provided in several small group meetings and 1:1 education. B. Audits to assure residents finger nails are clean and trimmed will occur 4x's per week for 3 weeks, then weekly audits for	12/10/18

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 10/26/2018

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 677	Continued From page 16 R2's nursing assistant group sheet directed staff to provide assistance of one staff for ADLs. On 10/23/18, at 9:36 a.m. R2's finger nails on both hands were very long and had a build-up of dark debris or dirt underneath, but above the tips of his fingers. R2 stated the staff would clean them if he asked, and further stated the staff do not clean them on bath day. On 10/24/18, at 8:15 a.m. R2 was observed sitting at the table in the dining room. R2's fingernails were long and dirty. On 10/25/18, at 8:25 a.m. R2 was sitting at the dining room table, and his fingernails were still long and dirty. On 10/25/18, at 9:42 a.m. nursing assistant (NA)-B stated nails should be clipped and cleaned on bath day, and for R2, that would be Sundays. NA-B stated they should also be checked for cleanliness during cares. On 10/25/18, at 10:53 a.m. NA-C stated she usually does R2's nails on bath day, but sometimes he refuses and sometimes she forgets when she gets busy with other things. NA-C stated she usually tries to soak them, and would need to get a brush to clean them. On 10/25/18, at 3:08 p.m. R2 stated he didn't think too much about his nails, but the ones on his left hand had started to bother him. R2 stated his girlfriend usually took care of his nails, but she had not done them and he had let them go too long.	F 677	4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Person responsible: Director of Nursing	

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 10/26/2018

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 677	Continued From page 17	F 677		

On 10/25/18, at 3:39 p.m. the director of nursing (DON) started she would have expected R2's nails to be done, trimmed and cleaned on bath day.

The facility policy Care of Fingernails/Toenails dated 11/17, indicated nail care included daily cleaning and regular trimming.

R23's Admission Record printed 10/26/18, indicated a diagnosis of Huntington's disease (a neurological disorder). R23's quarterly MDS dated 7/24/18, identified R23 as severely cognitively impaired. The MDS also indicated R23 was totally dependent upon staff for all activities of daily living (ADLs), including personal hygiene.

During observation on 10/22/18, at 1:44 p.m. R32 was in his room, seated and reclined in his wheelchair. R32 was noted to have long fingernails on all fingers, with both thumb nails being approximately 1/4 inch long.

On 10/23/18, at 11:40 a.m. in a telephone interview R23's family member (FM)-A, FM-A stated that the facility was "very inconsistent with grooming [R23]." FM-A stated R23 would of not like his nails being so long.

On 10/24/18, at 7:01 a.m. and again at 10:24 p.m. R23 was observed up and dressed for the day in the unit's dayroom. R23's finger and thumb nails of both hands remained untrimmed.

On 10/25/18, at 7:35 a.m. R23's nails remained untrimmed.

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 10/26/2018

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 677	Continued From page 18 During an interview on 10/25/18, at 7:40 a.m. NA-A stated she was one of the two who performed R23's morning cares. NA-A stated she was new to the unit and missed R23's nail needs. Registered nurse (RN)-A, who overheard the interview with NA-A, asked to see R23's nails. RN-A stated R23's nails were too long, and should have been trimmed on bath day. RN-A stated nursing assistants should let the nurse know if they do not have time to trim any resident nails.	F 677		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure mental health issues were assessed, and psychiatric services offered for 1 of 1 residents (R276) reviewed who had made suicidal statements and was assessed for behavioral-emotional health. Findings include: R276's Admission Record printed 10/26/18, indicated R276 was admitted on 8/8/18, with	F 740	Corrective Action: A. R276 was referred to and agreed to visit with MAPS (Mental Health Services and Therapists) 11/7/18. B. R276 was hospitalized for mental health assistance 10/30/18 and returned 11/6/18. C. R276 was placed on 15 minute checks for four days following residents return from the hospital 11/6/18. No abnormal behaviors or suicidal ideation noted	12/10/18

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 10/26/2018

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 740	Continued From page 19 diagnoses that included acute osteomyelitis (bone infection) of the left ankle and foot, adjustment and management of vascular access device (IV for antibiotic medications), encounter for change or removal of surgical wound dressing, and major depressive disorder. R276's admission Minimum Data Set (MDS) dated 8/19/18, indicated he was cognitively intact, had no signs or symptoms of delirium, had mild signs of depression, and did not have any physical or verbal behaviors that affected him or others. In addition, the MDS indicated R276 rejected cares 1-3 days during the 7 day assessment period. R276's care plan revised on 8/29/18, indicated R276 had the potential to demonstrate verbally abusive behaviors, was often irritable, demanding and not patient. Staff were directed to assess and anticipate R276's needs for food, thirst, toileting needs, comfort level, body positioning, pain,etc., assess R276's understanding of of the situation and allow time for the resident to express self and feelings toward the situation, monitor, report and document observed behaviors and attempted interventions in behavior log, and provide positive feedback for good behavior and emphasize the positive aspects of compliance. R276's lacked a plan to address depression, adjustment issues, or overall mental health. R276's Hospital Progress Note dated 8/26/18, indicated R276 had been offered several antidepressant medications while at the hospital, but refused.	F 740	during that time. 15 minute checks were reviewed by Interdisciplinary team and determined no longer necessary. D. R276 signed a 'no harm' contract with facility on 11/7/18. E. Referral and intake completed with St. Louis County who performed a referral to Human Development Center for diagnostic testing to determine if R276 is eligible for county mental health case manager. F. Social Services or designee has followed up at least weekly since hospital return 11/6/18 and will continue following up weekly for two months. G. Interdisciplinary team will offer to meet with R276 quarterly at residents' care conference to assure behavioral health needs are being addressed. Corrective Action as it applies to other Residents: A. A report of all residents with depression, major depressive disorder and mood disorder was compiled in order to review and ensure those residents' behavioral health needs are being addressed. B. A PointRight query indicating those residents flagging in mood was compiled. Facility staff assessed the residents from the PointRight list have behavioral health needs addressed. Recurrence will be prevented by: A. All staff educated on expectation of mental health follow up, 'Suicide	

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 10/26/2018

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 740	Continued From page 20 On 10/22/18, at 2:53 p.m. R276 was observed in bed watching television. R276 stated he had just been assigned to a new room; in the old room his roommate had an oxygen concentrator and a loud television, and he had not been able to sleep for weeks. R276 stated he reached the breaking point yesterday (10/21/18). R276 stated he took an extension cord, went to the smoking shack, got on a chair and tied the extension cord into a noose. R276 stated he then sat down on chair and started crying. R276 tearfully continued stating he was at the point yesterday that he was ready to do it (commit suicide). R276 stated he sat there for 4-5 minutes, and then got up and untied the extension cord and handed it to another resident, who took the extension cord inside to staff. R276 stated he had lost everything in the last year, and now he couldn't even sleep. R276 stated when he returned from the hospital yesterday, he was moved to a different room and slept from 10:00 p.m. until 12:00 noon today, and he felt a lot better. R276 stated no one had offered him therapy to deal with his losses or emotions, they just sent him to the hospital after the extension cord incident. R276 also stated when he moved to his new room he overheard staff saying he was just "playing the system." R276's progress notes since admission were reviewed and the following was identified: On 8/9/18, R276 completed admission paperwork with a social worker and indicated he didn't know where he would live when discharged from the facility. On 8/13/18, R276 met with the social worker and completed assessments. R276 didn't know	F 740	Precautions' policy, 'Mental Health Services' policy. B. Audits to assure residents behavioral health needs are addressed will occur 4x's per week for 3 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Person responsible: Social Services Director	

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 10/26/2018

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 740	Continued From page 21	F 740		

where he would live when discharged from the facility, and the social worker indicated she would assist with discharge planning. R276 told the social worker the physician had stated he may have to have his leg amputated, and that he was feeling down because of this potential. The note indicated the social worker would "continue to follow and assist as needed."

On 8/21/18, (regarding the social worker's meeting with R276 on 8/13/18) R276 expressed feeling down because of his health and the likelihood that he'd need an amputation in the near future. The note indicated R276 had been challenging to work with since admission, as he would reject cares and soon after be angry and demand that cares or medications be completed. R276 would also request appointments to be made, and then cancel or reschedule them. R276 wanted to make his own decisions and direct his own care, but wouldn't always follow physician orders.

On 8/24/18, (regarding the 8/13/18) R276 would have surgery to amputate part of his foot. The note further stated that R276 was worried about it, but felt it may be the best thing, and maybe his foot would finally heal. R276 didn't know where he would discharge to, and stated he was homeless. The note indicated R276 was very particular about his care and how things were done, and got irritated and sometimes angry if things weren't the way he wanted them. The note ended with, "Will assist as needed."

On 9/18/18, R276 was presented with a room change notice (from the transitional care unit and to a long term care room) due to his expressed

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 10/26/2018

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 740	Continued From page 22	F 740		

desire to stay in the facility, and he was no longer in therapy. R276 refused to sign the form indicating the facility would do what they wanted "You were supposed to be helping me, but no one is doing a damn thing." The social worker asked what R276 would like done, but R276 replied, "Nothing, forget it." The social worker reminded R276 that she was available, as well as other staff and the administrator, if he wanted to talk about concerns or complaints.

On 10/16/18, while R276 was out of the facility on a leave of absence that began at 4:35 a.m., another resident approached a staff person and expressed concerns about R276 as he had been making comments about ending his life by "doing a swan dive off the bridge," and had asked to go to a local hospital before something happened. The note further indicated R276 was depressed about his living situation, his foot, and being unable to work. The note indicated the social worker was informed, and subsequent attempts were made to call R276, but he did not answer. In addition, a family member was called and the family member had not heard from R276.

On 10/16/18, R276 returned to the facility in stable condition. Another note that same day indicated
R276 was asked if he had plans to harm himself, and R276 replied that he did not, but if he did he would let the writer know. R276 also told the writer he just wanted his foot to heal and get back to work. A later note that day indicated the social worker went to talk to R276 at 2:00 p.m. about the comments he had made to staff and another resident, but R276 had already left for an appointment.

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 10/26/2018

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 740	Continued From page 23 On 10/17/18, R276 was on report for concerning statements. R276 had told staff that if he couldn't sleep in a different room that night he was going to leave the facility. The note indicated no suicidal or depressed comments. Another note that day indicated the social worker met with R276 and asked him how he was doing. R276 replied with 2 thumbs up, and said, "Pretty good." The social worker reminded R276 that she was available to talk to about concerns, or if he felt frustrated. The note indicated the remainder of the conversation was about services and obtaining a waiver to enable R276 to live in the community upon discharge. On 10/21/17, R276 approached the nurses station very upset, and stated he hadn't been able to sleep due to his roommate, his foot throbbing, and a headache. R276 insisted upon getting his own room, and when told that could not be authorized, R276 replied that he was just going to to hang himself. The writer and another staff person observed R276 outside in the smoking area, and afterwards another resident showed staff the extension cord R276 had brought out to hang himself. Emergency services was called, and R276 was transferred to a local hospital for futher evaluation. R276 returned from the hospital that same day. During interview on 10/25/18, at 8:46 a.m. the administrator stated R276 had asked him if he could sleep in an empty room, and he told R276 no. The administrator stated R276 swore him and a nurse. The administrator stated he did not recall R276 complaining about the noise in his previous room, but R276 did treat staff gruffly,	F 740		

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 10/26/2018

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 740	Continued From page 24 and was not always approachable. On 10/25/18, at 2:22 p.m. R276 stated no staff had talked to him this week about how he was feeling after his suicidal ideation on 10/21/18. R276 stated no staff had approached him to offer counseling this week or any time during his stay at the facility. R276 stated at this time he would accept counseling, because how he was feeling "sucks." On 10/25/18, at 2:33 p.m. the director of social services (SS)-A stated she had not talked to R276 this week (since the 10/21/18 incident). On 10/25/18, at 3:05 p.m. registered nurse (RN)-C stated she talked to R276 briefly on Monday (10/22/18), when R276 moved to a room on her unit. RN-C stated she showed R276 where her office door was, told him she was always there, and to look her up. RN-C stated this was a conversation in the hallway as R276 was wheeling by. RN-C also stated she had told R276 that she had peaked into his room several days that week, but R276 was sleeping, and she wanted him to sleep, as he had had difficulties getting sleep when in another room on a different unit. RN-C stated R276 had told her he slept good on this unit. RN-C also stated she had not asked R276 if he was suicidal since the incident on 10/21/18, but she did acknowledge R276 had many losses in his life, and she understood how he must feel. On 10/25/18, at 3:30 p.m. RN-F stated she had not asked R276 if he still felt suicidal since he returned from the emergency room on 10/21/18.	F 740		

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 10/26/2018

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 740	Continued From page 25 On 10/25/18, at 3:42 p.m. social worker (SW)-B stated she had not talked to R276 that week. On 10/25/18, at 4:39 p.m. the director of nursing (DON) stated she chose to implement 15 minute checks on R276 after he returned from the hospital. The DON stated the hospital did call the facility while R276 was in the emergency room, and the DON had tried to convince them that R276 needed to be admitted. The DON stated she had asked the hospital, "How is that not a plan" (referring to the use of an extension cord to make a noose). The DON stated the hospital did not believe that was a plan, and they sent R276 back to the facility, and told the facility to give R276 a private room. The DON stated R276 had moved rooms numerous times during his admission, because he wanted a private room. The DON stated R276 currently felt great because he could sleep, and currently had no roommate. On 10/26/18, at 8:50 a.m. the DON stated she felt the facility handled R276's situation appropriately, and they have kept him safe. The DON stated R276 was exhibiting signs of being more comfortable: eating, sleeping, and talking to people in the hallway. The DON stated every time R276 verbalized trying to hurt himself it was about him wanting a private room. The DON confirmed that making an extension cord noose was a serious expression of asking for attention, that she had asked the hospital to admit R276 due to this incident, and she had not offered counseling or psychiatric follow-up after R276's return to the facility On 10/26/18, at approximately 8:52 a.m. RN-D	F 740		

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 10/26/2018

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 740	Continued From page 26 stated she had talked to R276 and a family member one day a while ago. The family member had told RN-D that R276 could not come and live with her, as she could not handle his moods and his disarray of thoughts. Behavior monitoring sheets for R276 were requested but not received from the facility. The facility's Mental Health Referrals policy revised 9/25/17, directed behaviors are observed by facility staff are to be documented in the resident's medical record. Behavior that appeared to be disturbed or indicated distress are called to the attention of the interdisciplinary team. The behaviors are discussed with the resident; and a physician referral would be obtained for mental health services. The facility's Suicide Precautions policy revised 9/25/17, directed all verbalizations or attempts at suicide would be taken seriously by all staff and receive follow-up. The policy directed staff to use the following communication strategies: be direct--talk openly about suicide; listen and allow expressions of feelings and accept the resident's feelings; be non-judgmental and do not debate if resident was right or wrong or the resident's feelings were good or bad; if feasible, get a verbal or preferable written agreement to no-suicide ("No matter what happens I will not kill myself"). The policy also directed staff to contact the resident's physician immediately with an update and to update the care plan if necessary.	F 740		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		12/10/18

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 10/26/2018

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 755	Continued From page 27 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff had the knowledge of proper disposal of fentanyl patches (an opioid patch delivery system), to prevent potential diversion. This had the potential to affect all 120	F 755	Corrective Action: A. Facility found the proper destruction of fentanyl patches was being practiced where the one resident with an order for fentanyl patch resides.	

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 10/26/2018

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 755	Continued From page 28 residents who resided in the facility. Findings include: During medication administration and storage review, of both licensed nursing staff, and trained medication assistants were interviewed, with the following being reported, as to how fentanyl used patches were to be disposed of: During an interview on 10/25/18 at 12:14 p.m., licensed practical nurse (LPN)-A, when asked how fentanyl patches were destroyed after use, LPN-A stated that with the witness of two staff, patches were flushed down the hopper (a flushable utility sink). The 2 staff would then sign off that the destruction occurred. In an interview on 10/25/18 at 12:19 p.m., a registered nurse (RN)-B stated that with the witness of 2 staff, the patches are coated with disinfectant and placed into a sharps container (a container where used syringes are placed). The 2 staff would then sign off that the destruction occurred. During an interview on 10/25/18 at 12:17 p.m., a trained mediation assistant (TMA)-A stated that the patches are cut up into pieces and placed in a sharps container, witnessed by 2 staff. The 2 staff would then sign off that the destruction occurred. In a final interview on 10/25/18 at 12:22 p.m., a registered nurse (RN)-A stated that two staff members were to flush the patch down the hopper. The 2 staff would then sign off that the destruction occurred.	F 755	Corrective Action as it applies to other Residents: A. All TMA's, LPN's and RN's were educated on the proper destruction of fentanyl patches. Education was provided in several small group meetings and 1:1 education. Recurrence will be prevented by: A. Audits to assure LPN's RN's and TMA's can demonstrate or describe the proper destruction of a fentanyl patch will occur 4x's per week for 3 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Person responsible: Director of Nursing	

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 10/26/2018

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 755	Continued From page 29 In review of a facility policy, entitled: Fentanyl Patch -Removal and Disposal Of (Merwin LTC Pharmacy - dated 12/01/16), indicated that after the patch was removed, the patch is to be folded in 1/2 with sticky sided together. Then "flush used patch down toilet/hopper, witnessed by a second staff member..." In an interview on 10/25/18 at 1:05 p.m., the director or nursing (DON) stated that the staff have been educated to flush fentanyl patches down the toilet/hopper with a witness of 2, as described in the facility policy. The DON provided information which indicated that currently, there is only one resident that has been prescribed the use of fentanyl patches.	F 755		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and	F 791		12/10/18

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 10/26/2018

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 791	Continued From page 30 (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to schedule a routine and follow-up dental appointment necessary to meet resident's need for 2 of 2 residents (R108, R53) reviewed for dental services. Findings include: R108's quarterly Minimum Data Set (MDS) dated 9/20/18, indicated R108 had intact cognition, could make herself understood when communicating, and had no rejection of care behaviors. R106's medical record lacked	F 791	Corrective Action: F 791- D - Dental Corrective Action: A. R108 dental appointment has been made with Lake Superior Dental. B. R35's responsible party stated to facility he would like to talk with the dentist before making any further decisions. Corrective Action as it applies to other Residents: A. Facility updated the care conference	

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 10/26/2018

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 791	Continued From page 31 documentation of dental or oral surgeon appointment. R108's Dental Assessment dated 6/27/18, indicated R108 had missing and broken teeth and had no dentures, no partial and no bridges. The assessment lacked as to whether R108 had been offered routine preventative dental care to address the broken and missing teeth. In addition, the assessment indicated "Resident has her own teeth, some broken, some missing no issues noted or seen on exam." R108's care plan dated 5/5/17,indicated Personal Hygiene/Oral Care: The resident requires set up assist with personal hygiene and oral care. Resident has her own teeth. Dental appointments as requested or recommended. On 10/22/18, at 3:02 p.m. R108 was interviewed, and stated she had broken and missing teeth on her lower and upper jaws. R108 opened her mouth and showed the broken and missing teeth. R108 also stated she sometimes had pain when chewing, and her teeth were bad. R108 stated she would like a dental appointment setup for her. R108 stated staff had never spoken to her regarding a dental appointment since admitted in the facility. In addition, R108 stated, "I would like to see a dentist or an oral surgeon." On 10/24/18 at 8:30 a.m. registered nurse (RN)-C was interviewed, and stated R108 would normally make her own appointments and make staff aware, but they did have an appointment for her. However, after review of R108's medical record, RN-C indicated R108 did not have an appointment set-up for neither the dentist nor oral	F 791	form to include a space for dental consult to assure dental needs are met for all residents. B. All residents will have initial oral assessments completed on all residents by 12/7/2018 and will be reevaluated quarterly. Recurrence will be prevented by: A. IDT team educated to complete the dental consult space on the care conference form at all resident care conferences. B. All staff educated on the findings of F791 and the corrective action the facility will make. C. Audits to assure residents oral care assessments will occur 4x's per week for 3 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when the audits may be discontinued. Person responsible: Director of Nursing	

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 10/26/2018

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 791	Continued From page 32	F 791		

surgeon at this point. RN-C added, "R108 never asked for dental or oral surgeon appointment."

The facility policy Dental Services dated 1/4/18, indicated dental services are to be available to meet the resident's oral health services in accordance with the resident's assessment and plan of care . Nursing Services is responsible for notifying social services of a resident's need for dental services based on oral assessments and resident agreement to services. If resident refuses services, documentation should be included to ensure appropriate care is offered. The facility will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary. R53's quarterly MDS dated 8/15/18, revealed R53 was in a comatose state.

On 10/22/18 at 6:31 p.m. R53's family member (FM)-B stated he would like R53 to see a dentist, but did not think she ever had, noting it was difficult due to R53's mouth posturing. FM-B explained he would like R53's gums looked at, and also stated she has four teeth. FM-B reported no one had ever spoke to him about R53 seeing the dentist, and it had been 3-4 years since R53 saw a dentist.

On 10/25/18 at 3:48 p.m. RN-G stated the facility did not have in-house dental services, and historically FM-B had not wanted R53 to go out for appointments. RN-G was not aware of the last time R53 was seen by a dentist. RN-G reported dental visits should be discussed during care conferences, and with quarterly oral exams.

On 10/26/18 at 8:33 a.m. the administrator stated

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 10/26/2018

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 791	Continued From page 33	F 791		

the facility did not have an arrangement with a dental provider to provide services for residents. The administrator stated he had attempted to secure a provider, but did not have documentation of attempts. The administrator stated there was only one clinic that accepted Medicaid in the area, and that dental care provider struggled to provide dental care for residents with physical and behavioral needs.

R53's dental Care Area Assessment (CAA) dated 12/4/17, indicated resident had no natural teeth or tooth fragments, and resident has no natural teeth. Resident has complete fluid intake provided through a feeding tube, so is not at risk for difficulty chewing foods related to no oral intake status, but is at risk for oral issues such as infection.

R53's Oral/Dental Assessment dated 8/14/18, indicated R53 did not have dentures, partials or bridges and did not have teeth. Under the question "Was oral exam completed?" was noted "Yes." However, the comments section indicated R53 has no teeth and doesn't wear dentures. Resident would not open mouth. No issues per staff." Under Date of last dental exam OR if refused, date offered: was left blank.

R53's care conference note dated 8/28/18, lacked information related to consults needed such as dental care.

The facility Dental Services policy dated 1/4/18, directed nursing services is responsible for notifying social services of a resident's need for dental services based on an oral assessment, and resident agreement to services. If the

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 10/26/2018

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 791	Continued From page 34 resident refuses services, documentation should be included to ensure appropriate care is offered. The MDS will also assess oral health on admit, quarterly, and annually to determine if there is a potential concern trigger in a care area that needs further assessing and care planning. Any notification of dental concerns will be discussed at IDT [interdisciplinary team] meeting for follow up. The facility will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.	F 791		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 812	Corrective Action:	12/10/18

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 10/26/2018

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 812	Continued From page 35 review, the facility failed to ensure that pans and serving dishes were dried before storage. In addition, the facility had 2 fans in the clean dish area and 1 fan in the cook's prep area that were visibly dusty. In addition, the facility failed to ensure proper sanitation of a food thermometer between temping various foods. These practices had the potential to affect 117 of 120 resident who ate food served from the facility kitchen. In addition, the facility failed to ensure no bare hand food touching was done during preparation of sandwiches and hamburgers, and hand sanitation between service of residents for 5 of 14 residents (R117, R114, R62, R2, and R87) who resided on the secured unit and who ate food served during the evening meal. Findings include: On 10/22/18, at 1:23 p.m. during the initial kitchen tour, dietary aide (DA)-A was observed stacking dirty dishes to run through the dishwasher. DA-D was observed stacking fruit cups together upside down when they came out of the dishwasher. The fruit cups came directly out of the dishwasher and were still wet. In addition, dinner plates were stacked together in the drying area. The dietary manager (DM) confirmed the dinner plates and fruit cups were still wet, and had not fully dried prior to stacking, or storage. In the same clean dish area, 2 fans were blowing on the clean dish area and both were visibly dusty. Another overhead fan was observed blowing on the food preparation area. The fan was covered with visible dust. The DM verified the dirty fans, and stated maintenance was responsible for cleaning fans, and he thought they cleaned them monthly.	F 812	A. A tag was placed on the kitchen fans to be visually inspected and documented weekly. Cleaning will be completed as needed based on the weekly inspections. Corrective Action as it applies to other Residents: A. Facility reviewed and revised 'Assistance with Meals' policy. B. Facility reviewed and revised the 'Food Thermometer Use' policy. C. Facility reviewed and revised the 'Proper Dishwashing/Storing of Dishes' policy. B. Facility Reviewed and revised the 'Preventing Foodborne Illness/Food Handling' policy. Recurrence will be prevented by: A. All staff educated on the 'Assistance with Meals' policy, and the corrective action the facility will make. Education was provided in several small group meetings and 1:1 education. B. All dietary staff educated on 'Proper Dishwashing/Storing of Dishes, Equipment and Utensils' policy, 'Food Thermometer Use' policy and 'Preventing Foodborne Illness/Food Handling. C. Audits to assure proper food handling, clean fans, proper drying of kitchen items and thermometer use will occur 4x's per week for 3 weeks, then weekly audits for 4 weeks, then monthly audits for 3 months. Findings will be reported monthly to the QAPI Committee for review and follow up recommendations. The QAPI Committee will determine when	

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 10/26/2018

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 812	Continued From page 36 During the same tour the following was found: three Hamilton Beach blenders were stored for clean use, and upon taking the top off, were still wet inside; one 6 inch steam table pan was wet, two 4 inch pans were wet, three clean cambro 4 inch square containers were wet; one 1/9 cambro rectangle container was wet, and all fruit cups checked were wet. All of these findings were confirmed by the DM. On 10/22/18, at 5:01 p.m. cook (C)-B was observed taking the temperature of tator tots in the steam table. When C-B finished temping the tots, she put the thermometer into it's case and stuck the unit into the back right pocket of her pants. C-B then moved to the food preparation area and made a puree of squash, put it in the microwave to warm up, took it out again, stirred it with a spoon, removed the thermometer from her back pocket, and without sanitizing, took the temperature of the squash. C-B then continued to use the thermometer to take the temperature of the supper meal's mashed potatoes, pureed fish, and hamburgers. Each time, C-B slipped the thermometer into its case and into her back right pants pocket. At no time did she clean or sanitize the thermometer. At 5:08 p.m. C-B stated she usually wipes the thermometer off with alcohol wipes between uses. C-B proceeded to rinse the thermometer off under running sink water. No alcohol wipes were available in the kitchen. On 10/25/18, at 10:00 a.m. the maintenance director (MD) stated they have a monthly check on items. The MD stated they took the fans down and cleaned them four or five months ago, and the two maintenance aides worked on that	F 812	the audits may be discontinued. Person responsible: Dietary Director and Director of Nursing	

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 10/26/2018

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 812	Continued From page 37	F 812		

together. The MD stated he thought there was a written record on this.

On 10/25/18, at 10:09 a.m. maintenance aide (MA)-B stated he cleaned the fans once earlier this year in April or May. MA-B stated he usually documented in their computer program so they will know when they did it. MA-B stated they had not been looking at the fans on a regular basis, and they did not know how dirty they would get, so fast.

On 10/25/18, at 1:45 p.m. the DM stated he expected staff to clean and sanitize thermometers when taking food temperatures, and to do this in between each food item. The DM stated alcohol wipes were available for use, but when showing the location, verified there were none available. The DM stated more were available in storage. The DM also stated thermometers should be put into their case and on the counter, they are not to be in staff pants pockets.

A facility work order printed 10/25/18, indicated the kitchen fans were last cleaned on 5/18/18, by MA-B.

The facility policy Manual Dishwashing undated, directed staff to allow dishes to air dry on the dish racks, and to inspect dishes for cleanliness and dryness.

The facility policy titled Preventing Foodborne Illness-Food Handling dated 1/4/18, indicated the facility recognized that a critical factor to foodborne illness was contaminated equipment. The policy directed all food service equipment

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 10/26/2018

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 812	Continued From page 38 and utensils would be sanitized according to current guidelines and manufacturers' recommendations. The policy lacked specific guidance on the cleaning and use of food thermometers. R117's Admission Record printed 10/26/18, indicated R117's diagnoses included dementia and history of a stroke. R117's quarterly Minimum Data Set (MDS) dated 10/5/18, indicated R117 required supervision and set up by staff for meals. R117's care plan initiated 7/3/18, did not address R117's eating. R114's Admission Record printed 10/26/18, indicated R114's diagnoses included dementia and Alzheimer's. R114's care plan initiated 12/7/16, directed staff to provide set up and supervision for eating. R62's Admission Record printed 10/26/18, indicated R62's diagnoses included dementia with Lewy Bodies (protein deposits in the brain that affects thinking, mood and behavior, and other functions) and Parkinson's disease. R62's care plan revised 6/25/17, directed staff to provide set up to eat, with assistance at time due to confusion and shakiness. R2's Admission Record printed 10/26/18, indicated R2's diagnoses included dementia, muscle weakness, and history of a stroke. R2's care plan revised 4/19/18, directed staff to provide one-to-one supervision with eating, but required extensive assistance of one staff at	F 812		

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 10/26/2018

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 812	Continued From page 39	F 812		

times.

R87's Admission Record printed 10/26/18, indicated R87's diagnoses included Parkinson's disease and dementia. R87's care plan revised 1/9/18, directed staff to provide supervision and cueing after set up for eating.

On 10/22/18, at 5:30 p.m. dinner trays were brought into the secured unit dining room. Nursing assistant (NA)-B sanitized her hands and began to ask residents if they wanted tartar sauce on their fish sandwiches. NA-B pulled out a tray from the cart and set it on the countertop next to the cart. NA-B used bare hands and took off the top bun of a fish sandwich for R117, applied tartar sauce, and put the top back on the sandwich. NA-b held the sandwich and cut it in half. NA-B Served the tray to R117. NA-B returned to the cart without sanitizing her hands. NA-B pulled out a tray from the cart and set it on the counter top next to the cart. NA-B took off the top bun of a fish sandwich for R114, applied tartar sauce and put the top back on the sandwich. NA-B held the sandwich with her hands and cut it in half. NA-B served the tray to R114. NA-B returned to the cart without sanitizing hands.
NA-B pulled out a tray, set it on the counter top next to the cart, and held the fish sandwich with her bare hands while she cut it in half. NA-B then served the tray to R62. NA-B returned and sanitized her hands prior to pulling out another tray, and served the tray to a resident without touching or cutting the sandwich. NA-B returned to sanitize her hands and removed another tray from the cart.
NA-B took the hamburger bun off with bare

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 10/26/2018

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 812	Continued From page 40	F 812		

hands, opened a ketchup packet, applied it to the hamburger, put the bun back on top with bare hands, held the burger with her bare hands and cut the hamburger and served the tray to R2. NA-B returned to sanitize her hands and removed another tray from the cart. NA-B brought R87 into the dining room, sanitized her hands, took the bun top off with her bare hands, put tartar sauce on after opening the packet, put the bun top back on and served the tray to R87. NA-B pulled up a chair, cut R87's sandwich while holding it with her hands.

On 10/23/18, at 11:34 a.m. NA-B verified she had touched the bread/buns with her bare hands while preparing them for the residents. NA-B stated she did not always sanitize her hands in between residents, and should have. NA-B stated she had caught herself half way through meal service, and started sanitizing.

On 10/25/18, at 3:39 p.m. the director of nursing (DON) verified she expected staff to use utensils to cut food and handle food, or wear gloves and change them between and sanitize hands between residents.

The facility policy Assistance With Meals revised 12/7/17, lacked direction for hand hygiene practices while preparing food for residents and assisting with dining between residents. The policy also lacked direction for no bare hand touching of food, and use of utensils.

The facility policy Handwashing/Hand Hygiene dated 11/28/17, lacked direction for staff to sanitize or wash hands prior to food service, and between serving or assisting different residents.

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 10/26/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2018**

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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Bayshore Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/15/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2018**

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
K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Bayshore Health Center is a 2-story building with a no basement. The original building was constructed in 1969 with an addition in 1978. The original building buildings and additions are all Type II (111) construction, therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 139 beds and had a census of 120 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2018**

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
K 000	Continued From page 2	K 000		
K 712 SS=E	The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 139 of 139 residents. Findings include: On facility tour between 11:00 a.m. to 2:00 p.m. on 10/24/2018, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was observed that the facility had conducted 3 day shift fire drills in the 5 a.m. hour.	K 712	Corrective Action: A. Facility will conduct fire drills on all three shifts throughout the year during varied times on each shift not within an hour of shift change. Responsible Party: Maintenance Director	12/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2018**

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
K 712	Continued From page 3 This deficient condition was confirmed by a Maintenance Supervisor.	K 712		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 9, 2018

Administrator
Bayshore Residence & Rehabilitation Center
1601 St Louis Avenue
Duluth, MN 55802

Re: State Nursing Home Licensing Orders - Project Numbers S5227030, H5227078, H5227079

Dear Administrator:

The above facility was surveyed on October 22, 2018 through October 26, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5227078, H5227079 that were found to be unsubstantiated. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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
	00589	A. BUILDING: _____ B. WING _____	C 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm.	2 000		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 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. On 10/22/18, to 10/26/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	2 000		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure cleaning and trimming of nails to maintain cleanliness and grooming for 1 of 2 residents (R2, R23) reviewed for activities of daily living (ADLs). Findings include: R2's Admission Record printed 10/26/18, indicated R2's diagnoses included dementia, muscle weakness, and cerebral infarction (stroke). R2's quarterly Minimum Data Set (MDS) dated 7/23/18, indicated R2 had a mild cognitive impairment, did not reject cares, and required extensive assistance of one staff for grooming.	2 920	Corrected	12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 3 R2's care plan revised 4/19/18, directed staff to provide extensive assistance of one staff for personal hygiene. R2's nursing assistant group sheet directed staff to provide assistance of one staff for ADLs. On 10/23/18, at 9:36 a.m. R2's finger nails on both hands were very long and had a build-up of dark debris or dirt underneath, but above the tips of his fingers. R2 stated the staff would clean them if he asked, and further stated the staff do not clean them on bath day. On 10/24/18, at 8:15 a.m. R2 was observed sitting at the table in the dining room. R2's fingernails were long and dirty. On 10/25/18, at 8:25 a.m. R2 was sitting at the dining room table, and his fingernails were still long and dirty. On 10/25/18, at 9:42 a.m. nursing assistant (NA)-B stated nails should be clipped and cleaned on bath day, and for R2, that would be Sundays. NA-B stated they should also be checked for cleanliness during cares. On 10/25/18, at 10:53 a.m. NA-C stated she usually does R2's nails on bath day, but sometimes he refuses and sometimes she forgets when she gets busy with other things. NA-C stated she usually tries to soak them, and would need to get a brush to clean them. On 10/25/18, at 3:08 p.m. R2 stated he didn't think too much about his nails, but the ones on his left hand had started to bother him. R2 stated	2 920		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 4 his girlfriend usually took care of his nails, but she had not done them and he had let them go too long. On 10/25/18, at 3:39 p.m. the director of nursing (DON) started she would have expected R2's nails to be done, trimmed and cleaned on bath day. The facility policy Care of Fingernails/Toenails dated 11/17, indicated nail care included daily cleaning and regular trimming. R23's Admission Record printed 10/26/18, indicated a diagnosis of Huntington's disease (a neurological disorder). R23's quarterly MDS dated 7/24/18, identified R23 as severely cognitively impaired. The MDS also indicated R23 was totally dependent upon staff for all activities of daily living (ADLs), including personal hygiene. During observation on 10/22/18, at 1:44 p.m. R32 was in his room, seated and reclined in his wheelchair. R32 was noted to have long fingernails on all fingers, with both thumb nails being approximately 1/4 inch long. On 10/23/18, at 11:40 a.m. in a telephone interview R23's family member (FM)-A, FM-A stated that the facility was "very inconsistent with grooming [R23]." FM-A stated R23 would of not like his nails being so long. On 10/24/18, at 7:01 a.m. and again at 10:24 p.m. R23 was observed up and dressed for the day in the unit's dayroom. R23's finger and thumb nails of both hands remained untrimmed.	2 920		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 5 On 10/25/18, at 7:35 a.m. R23's nails remained untrimmed. During an interview on 10/25/18, at 7:40 a.m. NA-A stated she was one of the two who performed R23's morning cares. NA-A stated she was new to the unit and missed R23's nail needs. Registered nurse (RN)-A, who overheard the interview with NA-A, asked to see R23's nails. RN-A stated R23's nails were too long, and should have been trimmed on bath day. RN-A stated nursing assistants should let the nurse know if they do not have time to trim any resident nails. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current grooming and personal hygiene policies and procedures to ensure nail care and hygiene is completed and maintained. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand	21000		12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21000	Continued From page 6 washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on Observation, interview, and document review, the facility failed to ensure no bare hand food touching was done during preparation of sandwiches and hamburgers, and hand sanitation between service of residents for 5 of 14 residents (R117, R114, R62, R2, and R87) who resided on the secured unit and who ate food served during the evening meal. Findings include: R117's Admission Record printed 10/26/18, indicated R117's diagnoses included dementia and history of a stroke. R117's quarterly Minimum Data Set (MDS) dated 10/5/18, indicated R117 required supervision and set up by staff for meals. R117's care plan initiated 7/3/18, did not address R117's eating. R114's Admission Record printed 10/26/18, indicated R114's diagnoses included dementia and Alzheimer's. R114's care plan initiated 12/7/16, directed staff to provide set up and supervision for eating. R62's Admission Record printed 10/26/18, indicated R62's diagnoses included dementia with Lewy Bodies (protein deposits in the brain that affects thinking, mood and behavior, and	21000	Corrected	

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21000	Continued From page 7 other functions) and Parkinson's disease. R62's care plan revised 6/25/17, directed staff to provide set up to eat, with assistance at time due to confusion and shakiness. R2's Admission Record printed 10/26/18, indicated R2's diagnoses included dementia, muscle weakness, and history of a stroke. R2's care plan revised 4/19/18, directed staff to provide one-to-one supervision with eating, but required extensive assistance of one staff at times. R87's Admission Record printed 10/26/18, indicated R87's diagnoses included Parkinson's disease and dementia. R87's care plan revised 1/9/18, directed staff to provide supervision and cueing after set up for eating. On 10/22/18, at 5:30 p.m. dinner trays were brought into the secured unit dining room. Nursing assistant (NA)-B sanitized her hands and began to ask residents if they wanted tartar sauce on their fish sandwiches. NA-B pulled out a tray from the cart and set it on the countertop next to the cart. NA-B used bare hands and took off the top bun of a fish sandwich for R117, applied tartar sauce, and put the top back on the sandwich. NA-b held the sandwich and cut it in half. NA-B Served the tray to R117. NA-B returned to the cart without sanitizing her hands. NA-B pulled out a tray from the cart and set it on the counter top next to the cart. NA-B took off the top bun of a fish sandwich for R114, applied tartar sauce and put the top back on the sandwich. NA-B held the sandwich with her hands and cut it in half. NA-B served the tray to R114. NA-B returned to the cart without sanitizing hands.	21000		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21000	Continued From page 8 NA-B pulled out a tray, set it on the counter top next to the cart, and held the fish sandwich with her bare hands while she cut it in half. NA-B then served the tray to R62. NA-B returned and sanitized her hands prior to pulling out another tray, and served the tray to a resident without touching or cutting the sandwich. NA-B returned to sanitize her hands and removed another tray from the cart. NA-B took the hamburger bun off with bare hands, opened a ketchup packet, applied it to the hamburger, put the bun back on top with bare hands, held the burger with her bare hands and cut the hamburger and served the tray to R2. NA-B returned to sanitize her hands and removed another tray from the cart. NA-B brought R87 into the dining room, sanitized her hands, took the bun top off with her bare hands, put tartar sauce on after opening the packet, put the bun top back on and served the tray to R87. NA-B pulled up a chair, cut R87's sandwich while holding it with her hands. On 10/23/18, at 11:34 a.m. NA-B verified she had touched the bread/buns with her bare hands while preparing them for the residents. NA-B stated she did not always sanitize her hands in between residents, and should have. NA-B stated she had caught herself half way through meal service, and started sanitizing. On 10/25/18, at 3:39 p.m. the director of nursing (DON) verified she expected staff to use utensils to cut food and handle food, or wear gloves and change them between and sanitize hands between residents. The facility policy Assistance With Meals revised 12/7/17, lacked direction for hand hygiene	21000		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21000	Continued From page 9 practices while preparing food for residents and assisting with dining between residents. The policy also lacked direction for no bare hand touching of food, and use of utensils. The facility policy Handwashing/Hand Hygiene dated 11/28/17, lacked direction for staff to sanitize or wash hands prior to food service, and between serving or assisting different residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), dietary manager, or designee could review and/or revise the current food handling policies and procedures to ensure food is not touched with bare hands during food service. The DON, dietary manager, or designee could educate the appropriate staff on the policies/procedures. The DON, dietary manager, or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced	21015		12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 10 by: Based on observation, interview, and document review, the facility failed to ensure 2 fans in the clean dish area and 1 fan in the cook's prep area that were clean. In addition, the facility failed to ensure proper sanitation of a food thermometer between temping various foods. These practices had the potential to affect 117 of 120 resident who ate food served from the facility kitchen. Findings include: On 10/22/18, at 1:23 p.m. during the initial kitchen tour, 2 fans were observed blowing on the clean dish area and both were visibly dusty. Another overhead fan was observed blowing on the food preparation area. The fan was covered with visible dust. The DM verified the dirty fans, and stated maintenance was responsible for cleaning fans, and he thought they cleaned them monthly. On 10/22/18, at 5:01 p.m. cook (C)-B was observed taking the temperature of tator tots in the steam table. When C-B finished temping the tots, she put the thermometer into it's case and stuck the unit into the back right pocket of her pants. C-B then moved to the food preparation area and made a puree of squash, put it in the microwave to warm up, took it out again, stirred it with a spoon, removed the thermometer from her back pocket, and without sanitizing, took the temperature of the squash. C-B then continued to use the thermometer to take the temperature of the supper meal's mashed potatoes, pureed fish, and hamburgers. Each time, C-B slipped the thermometer into its case and into her back right pants pocket. At no time did she clean or sanitize the thermometer. At 5:08 p.m. C-B stated she	21015	Corrected	

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 11 usually wipes the thermometer off with alcohol wipes between uses. C-B proceeded to rinse the thermometer off under running sink water. No alcohol wipes were available in the kitchen. On 10/25/18, at 10:00 a.m. the maintenance director (MD) stated they have a monthly check on items. The MD stated they took the fans down and cleaned them four or five months ago, and the two maintenance aides worked on that together. The MD stated he thought there was a written record on this. On 10/25/18, at 10:09 a.m. maintenance aide (MA)-B stated he cleaned the fans once earlier this year in April or May. MA-B stated he usually documented in their computer program so they will know when they did it. MA-B stated they had not been looking at the fans on a regular basis, and they did not know how dirty they would get, so fast. On 10/25/18, at 1:45 p.m. the DM stated he expected staff to clean and sanitize thermometers when taking food temperatures, and to do this in between each food item. The DM stated alcohol wipes were available for use, but when showing the location, verified there were none available. The DM stated more were available in storage. The DM also stated thermometers should be put into their case and on the counter, they are not to be in staff pants pockets. A facility work order printed 10/25/18, indicated the kitchen fans were last cleaned on 5/18/18, by MA-B. The facility policy titled Preventing Foodborne	21015		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 12 Illness-Food Handling dated 1/4/18, indicated the facility recognized that a critical factor to foodborne illness was contaminated equipment. The policy directed all food service equipment and utensils would be sanitized according to current guidelines and manufacturers' recommendations. The policy lacked specific guidance on the cleaning and use of food thermometers. SUGGESTED METHOD OF CORRECTION: The dietary manager, or designee could review and/or revise the current kitchen and food service hygiene policies and procedures to ensure cleanliness of the fans over the food preparation and service areas, and proper cleaning and handling of food thermometers during use to prevent contamination of food. The dietary manager or designee could educate the appropriate staff on the policies/procedures. The dietary manager or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21215	MN Rule 4658.0680 Subp. 9 Manual Cleaning and Sanitizing; Air Drying Subp. 9. Air drying. All dishes and utensils must be air dried before being stored or must be stored in a self-draining position. Properly racked sanitized dishes and utensils may complete air drying in proper storage places, if available.	21215		12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21215	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that pans and serving dishes were dried before storage. Findings include: On 10/22/18, at 1:23 p.m. during the initial kitchen tour, dietary aide (DA)-A was observed stacking dirty dishes to run through the dishwasher. DA-D was observed stacking fruit cups together upside down when they came out of the dishwasher. The fruit cups came directly out of the dishwasher and were still wet. In addition, dinner plates were stacked together in the drying area. The dietary manager (DM) confirmed the dinner plates and fruit cups were still wet, and had not fully dried prior to stacking, or storage. During the same tour the following was found: three Hamilton Beach blenders were stored for clean use, and upon taking the top off, were still wet inside; one 6 inch steam table pan was wet, two 4 inch pans were wet, three clean cambro 4 inch square containers were wet; one 1/9 cambro rectangle container was wet, and all fruit cups checked were wet. All of these findings were confirmed by the DM. The facility policy Manual Dishwashing undated, directed staff to allow dishes to air dry on the dish racks, and to inspect dishes for cleanliness and dryness. The facility policy titled Preventing Foodborne Illness-Food Handling dated 1/4/18, indicated the	21215	Corrected	

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21215	Continued From page 14 facility recognized that a critical factor to foodborne illness was contaminated equipment. The policy directed all food service equipment and utensils would be sanitized according to current guidelines and manufacturers' recommendations. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could review and/or revise the current dish and cooking pots and pans washing and drying policies and procedures to ensure proper drying prior to stacking and storage to prevent food-borne illnesses. The dietary manager or designee could educate the appropriate staff on the policies/procedures. The dietary manager or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21215		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies.	21325		12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to schedule a routine and follow-up dental appointment necessary to meet resident's need for 2 of 2 residents (R108, R53) reviewed for dental services. Findings include: R108's quarterly Minimum Data Set (MDS) dated 9/20/18, indicated R108 had intact cognition, could make herself understood when communicating, and had no rejection of care behaviors. R106's medical record lacked documentation of dental or oral surgeon appointment. R108's Dental Assessment dated 6/27/18, indicated R108 had missing and broken teeth and had no dentures, no partial and no bridges. The assessment lacked as to whether R108 had been offered routine preventative dental care to address the broken and missing teeth. In addition, the assessment indicated "Resident has her own teeth, some broken, some missing no issues noted or seen on exam." R108's care plan dated 5/5/17,indicated Personal Hygiene/Oral Care: The resident requires set up assist with personal hygiene and oral care. Resident has her own teeth. Dental appointments as requested or recommended. On 10/22/18, at 3:02 p.m. R108 was interviewed, and stated she had broken and missing teeth on her lower and upper jaws. R108 opened her mouth and showed the broken and missing teeth.	21325	Corrected	

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 16 R108 also stated she sometimes had pain when chewing, and her teeth were bad. R108 stated she would like a dental appointment setup for her. R108 stated staff had never spoken to her regarding a dental appointment since admitted in the facility. In addition, R108 stated, "I would like to see a dentist or an oral surgeon." On 10/24/18 at 8:30 a.m. registered nurse (RN)-C was interviewed, and stated R108 would normally make her own appointments and make staff aware, but they did have an appointment for her. However, after review of R108's medical record, RN-C indicated R108 did not have an appointment set-up for neither the dentist nor oral surgeon at this point. RN-C added, "R108 never asked for dental or oral surgeon appointment." The facility policy Dental Services dated 1/4/18, indicated dental services are to be available to meet the resident's oral health services in accordance with the resident's assessment and plan of care . Nursing Services is responsible for notifying social services of a resident's need for dental services based on oral assessments and resident agreement to services. If resident refuses services, documentation should be included to ensure appropriate care is offered. The facility will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary. R53's quarterly MDS dated 8/15/18, revealed R53 was in a comatose state. On 10/22/18 at 6:31 p.m. R53's family member (FM)-B stated he would like R53 to see a dentist, but did not think she ever had, noting it was difficult due to R53's mouth posturing. FM-B	21325		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 17 explained he would like R53's gums looked at, and also stated she has four teeth. FM-B reported no one had ever spoke to him about R53 seeing the dentist, and it had been 3-4 years since R53 saw a dentist. On 10/25/18 at 3:48 p.m. RN-G stated the facility did not have in-house dental services, and historically FM-B had not wanted R53 to go out for appointments. RN-G was not aware of the last time R53 was seen by a dentist. RN-G reported dental visits should be discussed during care conferences, and with quarterly oral exams. On 10/26/18 at 8:33 a.m. the administrator stated the facility did not have an arrangement with a dental provider to provide services for residents. The administrator stated he had attempted to secure a provider, but did not have documentation of attempts. The administrator stated there was only one clinic that accepted Medicaid in the area, and that dental care provider struggled to provide dental care for residents with physical and behavioral needs. R53's dental Care Area Assessment (CAA) dated 12/4/17, indicated resident had no natural teeth or tooth fragments, and resident has no natural teeth. Resident has complete fluid intake provided through a feeding tube, so is not at risk for difficulty chewing foods related to no oral intake status, but is at risk for oral issues such as infection. R53's Oral/Dental Assessment dated 8/14/18, indicated R53 did not have dentures, partials or bridges and did not have teeth. Under the question "Was oral exam completed?" was noted "Yes." However, the comments section indicated	21325		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 18 R53 has no teeth and doesn't wear dentures. Resident would not open mouth. No issues per staff." Under Date of last dental exam OR if refused, date offered: was left blank. R53's care conference note dated 8/28/18, lacked information related to consults needed such as dental care. The facility Dental Services policy dated 1/4/18, directed nursing services is responsible for notifying social services of a resident's need for dental services based on an oral assessment, and resident agreement to services. If the resident refuses services, documentation should be included to ensure appropriate care is offered. The MDS will also assess oral health on admit, quarterly, and annually to determine if there is a potential concern trigger in a care area that needs further assessing and care planning. Any notification of dental concerns will be discussed at IDT [interdisciplinary team] meeting for follow up. The facility will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current policies and procedures to ensure routine dental care services are offered and provided to residents. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing	21325		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 19 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 2 of 5 residents (R43,R61) and 5 of 5 employees (E-A, E-B, E-C, E-D, and E-E) had proper documentation of result as directed by Center for Disease Control (CDC) guidelines.	21426	Corrected	12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 20 Findings include: R43 was admitted to the facility 3/16/17, per admission record. R43's medical record lacked documentation of TB symptom screening. R43's medical record included documentation of R43 having received a first two-step tuberculin skin test (TST) on 3/16/17. Although the results were not documented to include millimeters of induration and interpretation of reading. R43 did not received the second two-step TST. R61 was admitted to the facility 12/8/17, per admission record. R61's medical record lacked documentation of first and second two-step tuberculin skin test (TST). E-A was hired on 10/4/18, E-A's personnel record included documentation of E-A having received a first two-step tuberculin skin test (TST) on 10/4/18. Although the results were not documented to include millimeters of induration and did not received the second two-step TST. E-B was hired on 9/10/18, E-B's personnel record lacked documentation of the second two-step tuberculin skin test (TST). E-C was hired on 8/9/18, E-C's personnel record lacked documentation of the second two-step tuberculin skin test (TST). E-D was hired on 9/20/18, E-D's personnel record lacked documentation of the second two-step tuberculin skin test (TST). E-E was hired on 7/25/18, E-E's personnel record lacked documentation of the second two-step	21426		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 21 tuberculin skin test (TST). On 10/25/18 at 2:11 p.m., registered nurse (RN)-C and RN-D confirmed that TST documentation was supposed to include the baseline TB symptoms screening, 2-step testing, millimeters of induration, and interpretation of reading. RN-D indicated, she identified the documentation was lacking TST steps and TB symptoms screening. RN-D added, this does not meet the facility expectations; staff will be retrained/reeducated on this concerns. Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening Health Care Workers (HCWs) directed "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative Interferon-Gamma Release Assays [IGRA] (blood test) or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients... Serial TB screening Serial TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a one-step TST or single IGRA... General principles ·All reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations should be maintained in the employee's record. ·TST documentation should include the date of the test (i.e., month, day, year), the number of	21426		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 22 millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative) ..." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies regarding TB screening, could educate staff and could ensure audits were conducted to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the	21630		12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21630	Continued From page 23 person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff had the knowledge of proper disposal of fentanyl patches (an opioid patch delivery system), to prevent potential diversion. This had the potential to affect all 120 residents who resided in the facility. Findings include: During medication administration and storage review, of both licensed nursing staff, and trained medication assistants were interviewed, with the following being reported, as to how fentanyl used patches were to be disposed of: During an interview on 10/25/18 at 12:14 p.m., licensed practical nurse (LPN)-A, when asked how fentanyl patches were destroyed after use, LPN-A stated that with the witness of two staff, patches were flushed down the hopper (a flushable utility sink). The 2 staff would then sign off that the destruction occurred. In an interview on 10/25/18 at 12:19 p.m., a registered nurse (RN)-B stated that with the witness of 2 staff, the patches are coated with disinfectant and placed into a sharps container (a container where used syringes are placed). The 2 staff would then sign off that the destruction occurred. During an interview on 10/25/18 at 12:17 p.m., a	21630	Corrected	

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21630	Continued From page 24 trained mediation assistant (TMA)-A stated that the patches are cut up into pieces and placed in a sharps container, witnessed by 2 staff. The 2 staff would then sign off that the destruction occurred. In a final interview on 10/25/18 at 12:22 p.m., a registered nurse (RN)-A stated that two staff members were to flush the patch down the hopper. The 2 staff would then sign off that the destruction occurred. In review of a facility policy, entitled: Fentanyl Patch -Removal and Disposal Of (Merwin LTC Pharmacy - dated 12/01/16), indicated that after the patch was removed, the patch is to be folded in 1/2 with sticky sided together. Then "flush used patch down toilet/hopper, witnessed by a second staff member..." In an interview on 10/25/18 at 1:05 p.m., the director or nursing (DON) stated that the staff have been educated to flush fentanyl patches down the toilet/hopper with a witness of 2, as described in the facility policy. The DON provided information which indicated that currently, there is only one resident that has been prescribed the use of fentanyl patches. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current medication destruction policies and procedures to ensure controlled medications are properly destroyed to prevent diversion. The DON or designee could educate the appropriate staff on the policies/procedures.	21630		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21630	Continued From page 25 The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure housekeeping services provided a clean environment for 1 of 1 residents (R9) who room had unkept tube feeding equipment. In addition, the facility failed to maintain water temperatures within acceptable levels on 1 of 8 units (100 unit) on which residents complained of water being too cold. Findings include: During the initial facility tour on 10/22/18, at 5:14 p.m. it was observed in R9's room the resident care equipment was soiled. R9's tube feeding pump was coated in dried tan feeding solution. The IV (intravenous) pole (from the feeding pump to the wheeled base) was also coated with dried tan feeding solution. Above the feeding pump there was large quantity of paper tape wrapped around the IV pole, also coated with feeding solution.	21665	Corrected	12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 26 During the environmental tour on 10/24/18, at 2:52 p.m. the maintenance director (MD) and the administrator both verified the entire enteral feeding set up (pump and IV pole) were soiled and should have been cleaned. The facility policy Cleaning and Disinfection of Resident-Care Items and Equipment dated 1/4/18, directed only what cleaning products were to be used, which depended on manufacturer's instructions. No further information was provided. During a resident interview on 10/23/18, at 3:20 p.m. R118 stated the bathroom water was always cold. On 10/23/18, at 3:32 p.m. R99 stated the water in the bathroom never got hot. R99 stated he received a daily bed bath, and it was upsetting his cares were performed with cold water. Both R9 and R118 resided on the facility's 100 unit. During the environmental tour on 10/24/18, at 2:44 p.m., the maintenance director (MD) and the administrator took water temperatures in both rooms, obtaining only 88-89 degrees Fahrenheit (F) after the water had ran for 5 minutes. Both MD and the administrator stated about a month ago during a boiler inspection, they noted a 110 F temperature, receiving a recommendation to turn the boiler temperature down for resident safety. MD stated the facility had two boilers and a hot water holding tank, which were located on the facility's roof, in an enclosed structure. MD stated now that the weather was getting colder, the	21665		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 27 settings may have to be readjusted. MD and the administrator both stated the facility takes daily temperatures in random locations throughout the facility. On 10/25/18, at 7:10 a.m. the administrator provided further information that MD adjusted the boiler setting twice yesterday (10/24/18), and finally achieved 111 F on the unit where these two rooms were located. However, on 10/25/18, at 7:19 a.m. during a follow up water temperature check with MD and the administrator the water was let to run in a random room on the 100 unit. After 3 minutes the temperature was 103 F, and after 5 minutes 108 F was obtained. In review of the facility's water temperature logs (7/09/18, through 10/25/18), water temperatures were recorded to be between 94.0 - 106.7 F for at least 1 of the 2 rooms randomly checked on 35 days by the facility. The facility policy Water Temperatures, Safety Of dated of 1/4/18, directed water heaters/boilers that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of not more than 120 F, or the maximum allowable temperature per state regulation. The policy further directed maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. SUGGESTED METHOD OF CORRECTION: The environmental services manager (ESM) or designee could review and/or revise the current	21665		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 28 proper water temperatures and cleanliness of medical equipment policies and procedures to ensure proper water temperature for resident comfort, and cleanliness of resident medical equipment. The ESM or designee could educate the appropriate staff on the policies/procedures. The ESM or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that	21880		12/10/18

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 29 provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow up on a written grievance for 1 of 2 residents (R29) reviewed for grievances. Findings include: R29's quarterly Minimum Data Set (MDS) dated 8/1/18, indicated R29 was cognitively intact and had a diagnosis of paraplegia. Review of a room change notice, dated 7/16/18, indicated, "This letter is to notify you that in seven days will be moved to room [room number] Reason: you will be moved from a double room	21880	Corrected	

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 30 to a private room." The form further directed, "You have a right to contest this action, you may do so with the Social Service Department or the Nursing Department. You are also free to contact the Long Term Care Ombudsman" R29 signed and wrote a response "I wish to stay in my room [room number] I'd like to be taken care of same staff I have for over 2 1/2 years and see my doctor about my continued care here. I understand that I will have a roommate if I remain on [unit]." On 10/22/18, at 4:03 p.m. R29 reported he was moved from a different room and unit about eight months ago. R29 stated, "I was a lot happier [on the other unit]" and added it was quieter, staff treated him better and it did not take so long to get a call light answered on his previous unit. R29 stated, "I was just baffled and all they said was 'we're just protecting you because you'll have a private room.' I had two or three different roommates while I was [on the other unit] but for the most part I had the room to myself." On 10/24/18, at 2:14 p.m. registered nurse (RN)-A stated she had questioned why R29 was moved to his current unit, explaining that there were a lot of residents with heavy care needs. RN-A stated R29 had complained he felt ignored. On 10/25/18, at 8:29 a.m. the director of social service (SW)-A stated R29 was moved to his current unit due to his age and problems with previous roommates. SW-A stated she would look into how the facility addressed R29's concerns. On 10/25/18, at 2:55 p.m. SW-A and SW-B stated the facility was only required to provide a seven day notice of room change, and the facility	21880		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 31 was not required to follow up with R29's concern related to the room change. SW-B stated she told R29 to contact the ombudsman (resident advocate employed by the state) if he wanted to appeal the move. SW-A and SW-B both verified there was no documentation of follow up related to R29's concern regarding the room change. Review of a word document signed by SW-B undated, indicated SW-B was aware R29 wanted to stay in his room. SW-B told R29 he would get a roommate if did not move. SW-B documented she instructed R29 he needed to contact the ombudsman if he did not want to move. A review of a word document signed by the administrator dated 10/26/18, indicated the administrator wrote he was made aware of R29 not wanting to move rooms. The administrator wrote that he instructed R29 to contact the ombudsman, and R29 may need to go before an administrative law judge to appeal the move. The administrator documented he explained to R29 the benefits of having his own room. The facility Resident Concern policy revised 1/7/17, directed staff that residents or their representatives wishing to register a concern may request to see any employee of Bayshore Residence and Rehabilitation. The resident may request the assistance of an advocate. The concern may be written or presented orally. If written, a concern form will be reported to [state agency] if suspected or reported maltreatment is noted by the complainant. Oral grievances will be handled in the same manner immediately. The policy further directed all concerns will be immediately submitted to the charge nurse on duty and followed up. Information will be	21880		

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 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 32 gathered regarding the concern and an assessment of the situation will be made by the facility. All concerns will be investigated per facility protocol. All concerns will be logged by social services into internal concern logs and trended for any patterns. All patterns will be reviewed at QA [quality assurance] meeting. All originals will be maintained by social service director. The policy further directed acknowledgement of receipt of the concern with notification to DON [director of nursing], social worker and administrator. Interview with resident or representative to clarify nature of complaint. All complainants will be notified of a resolution. All concerns will be resolved within 30 days, and a notification letter provided to the complainant, except in extenuating circumstances that have been explained to, and are acceptable to the complainant. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), social worker (SW) or designee could review and/or revise the current grievances/concerns policies and procedures to ensure residents receive an appropriate and written resolution. The DON, SW or designee could educate the appropriate staff on the policies/procedures. The DON, SW or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		