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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8I39

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) **183488600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE HEALTH CENTER**
(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) **08/01/2002**

6. DATE OF SURVEY **12/20/2012** (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 IMR	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 **160** (L18)

13.Total Certified Beds **160** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	160			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Chris Elmgren, HFE-NEII 01/15/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 01/15/2013 (L20)

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

19. DETERMINATION OF ELIGIBILITY
__X__ 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.
52280
(L31)

30. REMARKS
Posted 1/25/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/18/2012
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on October 26, 2012, this Special Focus Facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility was given an opportunity to correct before remedies are imposed.

On December 20, 2012, the Minnesota Department of Health and on December 6, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on October 26, 2012, effective December 7, 2012. Therefore, the remedies outlined in our letter dated November 7, 2012 will not be imposed. See attached CMS-2567B for the results of the December 20, 2012, and December 6, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5227

January 15, 2013

Ms. Susan Koivisto, Administrator
Bayshore Health Center
1601 St Louis Avenue
Duluth, Minnesota 55802

Dear Ms. Koivisto:

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 7, 2012 the above facility is recommended for:

160 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 160 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 15, 2013

Ms. Susan Koivisto, Administrator
Bayshore Health Center
1601 St Louis Avenue
Duluth, Minnesota 55802

RE: Project Number S5227023

Dear Ms. Koivisto:

On November 7, 2012, 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, 2012. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 20, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 6, 2012 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, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 7, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2012, effective December 7, 2012 and therefore remedies outlined in our letter to you dated November 7, 2012, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing	12/20/2012

Name of Facility	Street Address, City, State, Zip Code
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0165** Reg. # **483.10(f)(1)** LSC	Correction Completed **12/07/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **12/07/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/07/2012**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/07/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/07/2012**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/07/2012**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **12/07/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/07/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/07/2012**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PH/NCS	1/15/13	12831	12/20/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/26/2012			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing 01 - MAIN BUILDING 01	12/6/2012

Name of Facility	Street Address, City, State, Zip Code
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	11/01/2012	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/NCS	Date: 1/15/13	Signature of Surveyor: 03005	Date: 12/6/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/25/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 15, 2013

Ms. Susan Koivisto, Administrator
Bayshore Health Center
1601 St Louis Avenue
Duluth, Minnesota 55802

Re: Enclosed Reinspection Results - Project Number S5227023

Dear Ms. Koivisto:

On December 20, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 26, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00589	A. Building B. Wing	12/20/2012

Name of Facility	Street Address, City, State, Zip Code
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **12/07/2012**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **12/07/2012**	ID Prefix **20840** Reg. # **MN Rule 4658.0520 Subp. 2 B** LSC	Correction Completed **12/07/2012**
ID Prefix **20850** Reg. # **MN Rule 4658.0520 Subp. 2 D** LSC	Correction Completed **12/07/2012**	ID Prefix **21385** Reg. # **MN Rule 4658.0800 Subp. 3** LSC	Correction Completed **12/07/2012**	ID Prefix **21615** Reg. # **MN Rule 4658.1340 Subp. 2** LSC	Correction Completed **12/07/2012**
ID Prefix **21880** Reg. # **MN St. Statute 144.651 Subd. 2** LSC	Correction Completed **12/07/2012**	ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Subd. 8** LSC	Correction Completed **12/07/2012**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	Correction Completed **12/07/2012**
ID Prefix **21995** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	Correction Completed **12/07/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PH/NCS	1/15/13	12831	12/20/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/26/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8I39

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) **183488600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BAYSHORE HEALTH CENTER**
(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) **08/01/2002**

6. DATE OF SURVEY **10/26/2012** (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 IMR	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 **160** (L18)

13.Total Certified Beds **160** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	160			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Cynthia Green, HFE-NEII 11/26/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 12/15/2012 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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.
52280
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5227
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on October 26, 2012, this Special Focus Facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit after December 7, 2012.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8809

November 7, 2012

Ms. Susan Koivisto, Administrator
Bayshore Health Center
1601 St Louis Avenue
Duluth, Minnesota 55802

RE: Project Number S5227023

Dear Ms. Koivisto:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On October 26, 2012, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 723-4637

Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 5, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 26, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MLTPLE BLDG	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This is a Special Focus Facility. THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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 REGULATIONS HAS' BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	OK 11/20/12 PLH F165 RIGHT TO VOICE GRIEVANCES 1. Corrective Action: a) Resident R164 nutritional assessment and plan of care will be reviewed updated as needed to reflect client's nutritional needs and choice. b) **100% Audit of all grievances submitted as of 10/26/12 to ensure proper processing and follow up, all grievances will be reviewed and audited by Social Service Director to ensure compliance to revised policy. Audit of all grievances will be conducted weekly for two months and then monthly for 3months to assure all staff understand the proper protocol when processing grievances and staff education is provided as needed.**	
F 165 SS=D	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility did not address grievances for 1 of 9 residents (R164) reviewed for abuse prohibition. Findings include: R164 filed a grievance regarding not getting enough food to eat at breakfast. During the survey R164 was denied his request for more	F 165		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Kourosto — TITLE: Administrator — (X6) DATE: 11/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institu

tion 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTIPLE BUILDING	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	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 165	Continued From page 1 eggs. The nutritional care area assessment (CAA) dated 4/9/12, indicated R164's intake ranged from 50-75% at meals and he was at risk for developing nutritional and hydration concerns. The assessment also indicated staff would honor R164's preferences to promote weight stability. The quarterly Minimum Data Set (MDS) dated 9/26/12, indicated R164's cognition was intact. The nutritional care plan dated 8/2/12, indicated R164 had potential for alteration in nutrition and hydration. The care plan directed staff to assure R164 received double portions at meals as he frequently requested extra portions, but sometimes forgets to ask, then later becomes upset that he didn't receive extra food. The interventions on the care plan included to honor R164's preferences and offer alternatives for food refusals and double portions as agreed upon with R164 and his family. On 8/29/12, R164 filed a grievance with the Social Worker (SW)A, stating the kitchen was not making enough eggs for breakfast and that he would like more. The Dietary Service Director (DSD)'s typed note dated 8/30/12, indicated R164 received double portions at breakfast per his request. However, the cook had thrown out the eggs before R164 requested more. The DSD note indicated R164 was directed to ask for more food when he received his plate or before the dietary server left the dining room, R164 filed another grievance with SW-A on 10/15/12. R164 reported that a staff member took away one of his two milk servings because	F 165	2. Corrective Action as it applies to other clients: a) 100% audit will be conducted for all clients' nutritional assessment and plan of care to reflect client's nutritional needs and choice. b) Portion Options Policy will be revised to include option for choices secondary to double portion. c) Grievance Policy will be updated to ensure they are handled and followed up appropriately. d) All grievances will be logged into the incidents log and followed up for proper processing by Director of Social Services. e) **Social Services will receive notifications of all grievances and assure the process of reporting, follow up and investigation as needed is taken.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTIPLE CONSTRUCTION	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOWS 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 165	Continued From page 2 he didn't drink the second milk the day before. R164 wanted two milk servings at his meals. Attached to the grievance form was an undated response from SW-A that indicated the staff member had been spoken to; however, there was no evidence of a response to R164. On 10/24/12, at 9:00 a.m., R164 approached the surveyor in the main dining room and asked if there was a law against getting more eggs if someone wants more to eat. R164 stated he was told he could not have any more eggs even though he was still hungry. The cook was interviewed at this time and stated,"per the policy those residents who request double portions only get the double portions that's what I was told." The dietary supervisor (DS) was interviewed on 10/24/12, at 9:10 am. and stated they have a policy that indicates residents who receive double portions are to speak directly to the dietary supervisor if they want more food. The DS stated she had talked to R164 in the past regarding wanting more than double portions and instructed him to ask for a "snack" at the nurses station. The DS stated she was not aware of R164's grievance from 10/15/12, regarding not getting 2 milks per his request. The policy titled Resident Grievances with a reviewed/revised date of 3/17/11, indicated all grievances will be submitted to the appropriate department manager and a copy will be sent to social services for review. The policy also stated all grievances will be responded to promptly (within 5 days) and followed up with the responsible party. Although social services had received the grievance, the DS had not, and R164 was not provided resolution regarding the	F 165	3. Reoccurrence will be prevented by: a) All Bayshore staff will be educated on the updated Portion Option Policy. b) All Bayshore staff will be educated on Resident's Bill of Rights and provide quick reference sheets in all units/departments to help us remember them. c) **Reoccurrences will be managed by keeping a record of all grievances to ensure proper processing and follow up at which time any staff not following with process for processing grievances will be educated independently and or disciplined appropriately.** 4. The Correction will be monitored by: a) DON, Nurse Managers, Dietary and Social Services. 5. Date of completion: 12/7/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	BLDG _____ WING _____	10126/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 165	Continued From page 3 milk grievance.	F 165	F225 INVESTIGATE / REPORT ALLEGATIONS/INDIVIDUALS	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	1. Corrective Action: a) Resident R121 will have complaint of 9/6/12 thoroughly investigated to determine potential mistreatment. b) Resident R74 will have complaint of 6/15/12 thoroughly investigated to determine potential mistreatment. c) **100% Audit of all grievances submitted as of 10/26/12 to ensure proper processing and follow up, all grievances will be reviewed and audited by Social Service Director to ensure compliance to revised policy. Audit of all grievances will be conducted weekly for two months and then monthly for 3months to assure all staff understand the proper protocol when processing grievances and staff education is provided as needed.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	BLDG _____ WING _____	10/26/2012

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to incidents to determine potential mistreatment for 2 of 5 residents (R121, R74) who were reviewed for abuse prohibition. Findings include: R121's report of rough treatment by staff was not thouroughly investigated to determine potential mistreatment. A grievance /complaint form dated 9/6/12, was completed by a registered nurse (RN) on behalf of R121 with the chief investigator identified as licensed social worker (LSW)-G. The description of the incident is as follows: The nurse practitioner (NP) called to report that R121 stated he gets a sore on his bottom when sitting for long periods of time and that some staff at Bayshore are "too rough" with him when pulling his pants up. R121 also stated it's only certain staff and that others were "very good". LSW-G signed and dated the document as reviewed on 9/7/12. The Administrator signed and dated it as reviewed on 9/24/12. LSW-G's late entry progress note dated for 9/7/12, indicated she talked with R121 who stated staff were rough when pulling up his pants, hurting his coccyx pressure ulcer. LSW-G encouraged R121 to tell staff "ouch, stop!" or in some manner let staff know that it indeed hurt him. A memo dated 9/10/12, was placed on the nursing unit to notify staff about the proper care when pulling up R121's pants and to stop when signs and symptoms of discomfort were observed.	F 225	2. Corrective Action as it applies to other clients: a) Resident Grievance Policy will be revised to ensure that all alleged violations including maltreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the OHFC/ CEP as required and that all allegations are thoroughly investigated. **b) Social Services will receive notifications of all grievances and assure the process of reporting, follow up and investigation as needed is taken.** 3. Reoccurrence will be prevented by: a) All Bayshore staff will be educated on the Resident Grievance Policy. b) All Bayshore staff will be educated on the Vulnerable Adult Reporting responsibilities. **c) Reoccurrences will be managed by keeping a record of all grievances to ensure proper processing and follow up at which time any staff not following with process for processing grievances will be educated independently and or disciplined appropriately.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTIPLE CONSTRUCTION / BLDG	10/26/2012 .

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 225	Continued From page 5 R121's diagnoses included end stage renal disease, congestive heart disease (CHF), and 2 stage 2 coccyx pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer). The 5-day Minimum Data Set (MDS) dated 10/12/12, indicated R121 had intact cognition and needed extensive assistance with activities of daily living (ADLs).The care plan dated 9/10/12, identified R121 had an ulcer to his coccyx. Interventions included personal care assistance in a mindful manner related to potential pain to the coccyx site. Stop if signs and symptoms of pain are noted/verbalized. Pull pants up by pulling over the ulcer to decrease friction/contact to the site. R74's report of lack of personal care during the night was not thouroghly investigated to determine potential mistreatment. R74's Grievance/Complaint Documentation and Follow-up Report dated 6/15/12, indicated a lack of care during the night. R74's diagnoses include generalized muscle weakness, secondary hyperparathyroidism, osteopenia, osteomyelitis, diabetes mellitus type 2, peripheral neuropathy, morbid obesity, affective psychosis, major depressive disorder, anxiety, Parkinson's disease, restless leg syndrome, blindness, congestive heart failure, stasis dermatitis, renal failure, chronic kidney disease, severe osteoarthritis and insomnia. The Quarterly Minimum Data Set (MDS) dated 10/15/12, indicated R74 was cognitively intact, required extensive assistance with bed mobility and transfers, was occasionally incontinent of bladder, and always incontinent of bowel.	F 225	4. The Correction will be monitored by: a) DON, Nurse Managers and Social Services. 5. Date of completion: 12/7/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTIPLE BUILDING	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 225	Continued From page 6 The Plan of Care dated April, 2012, indicated R74 required full body mechanical lift and assist of two persons for transfers. R74 requested repositioning at night and staff were to offer repositioning every 2 hours and pm (as needed). Staff to encourage R74 to use call light to notify staff of need to void and to keep the call light within reach. Nursing assistant charting from 6/15/12, indicated R74 was seen every two hours but lacked specifics as to what cares were provided. Interview with social worker (SW)-F and the Interim Director of Nursing (IDON) on 10/25/12, at 1:30 p.m. indicated they investigated R74's statement by talking with other alert residents on the unit (all of whom stated their care was provided) and by reviewing the group sheets (nurse aide documentation) showing the care was provided to R74. Although R74 was cognitively intact, they were not interviewed as part of the investigation. The IDON stated the grievance should have been immediately reported to the administrator and the state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 7 Based on interview and document review, the facility failed to operationalize their abuse prevention policy regarding investigating incidents of potential mistreatment for 2 of 5 residents (R121, R74) reviewed for abuse prohibition. Findings include: The Abuse Prevention Plan dated 12/16/11, directed the facility professional who received a report of suspected resident mistreatment to immediately report the incident to the Administrator and state agency. The Administrator was responsible for ensuring that an internal investigation is completed and the results are reported to the state agency. R121's report of rough treatment by staff was not thouroughly investigated to determine potential mistreatment. A grievance /complaint form dated 9/6/12, was completed by a registered nurse (RN) on behalf of R121 with the chief investigator identified as licensed social worker (LSW)-G. The description of the incident is as follows: The nurse practitioner (NP) called to report that R121 stated he gets a sore on his bottom when sitting for long periods of time and that some staff at Bayshore are "too rough" with him when pulling his pants up. R121 also stated it's only certain staff and that others were "very good". LSW-G signed and dated the document as reviewed on 9/7/12. The Administrator signed and dated it as reviewed on 9/24/12. LSW-G's late entry progress note dated for 9/7/12, indicated she talked with R121 who stated staff were rough when pulling up his pants, hurting his coccyx pressure ulcer. LSW-G encouraged R121 to tell staff "ouch, stop!" or in some manner let staff know that it indeed hurt him. A memo dated 9/10/12, was placed on the	F 226	F226 DEVELOPENT/IMPLEMENTATION ABUSE/NEGLECT POLICIES 1. Corrective Action: a) Resident R121 will have complaint of 9/6/12 thoroughly investigated to determine potential mistreatment. b) Resident R74 will have complaint of 6/15/12 thoroughly investigated to determine potential mistreatment. c) **100% Audit of all grievances submitted as of 10/26/12 to ensure proper processing and follow up, all grievances will be reviewed and audited by Social Service Director to ensure compliance to revised policy. Audit of all grievances will be conducted weekly for two months and then monthly for 3months to assure all staff understand the proper protocol when processing grievances and staff education is provided as needed.**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTIPLE BUILDING	10/26/2012

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F 226	Continued From page 8 nursing unit to notify staff about the proper care when pulling up R121's pants and to stop when signs and symptoms of discomfort were observed. R121's diagnoses included end stage renal disease, congestive heart disease (CHF), and 2 stage 2 coccyx pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer). The 5-day Minimum Data Set (MDS) dated 10/12/12, indicated R121 had intact cognition and needed extensive assistance with activities of daily living (ADLs).The care plan dated 9/10/12, identified R121 had an ulcer to his coccyx. Interventions included personal care assistance in a mindful manner related to potential pain to the coccyx site. Stop if signs and symptoms of pain are noted/verbalized. Pull pants up by pulling over the ulcer to decrease friction/contact to the site. R74's report of lack of personal care during the night was not thouroghly investigated to determine potential mistreatment. R74's Grievance/Complaint Documentation and Follow-up Report dated 6/15/12, indicated a lack of care during the night. R74's diagnoses include generalized muscle weakness, secondary hyperparathyroidism, osteopenia, osteomyelitis, diabetes mellitus type 2, peripheral neuropathy, morbid obesity, affective psychosis, major depressive disorder, anxiety, Parkinson's disease, restless leg syndrome, blindness, congestive heart failure, stasis dermatitis, renal failure, chronic kidney disease, severe osteoarthritis and insomnia. The Quarterly Minimum Data Set (MDS) dated	F 226	2. Corrective Action as it applies to other clients: a) Resident Grievance Policy will be revised to ensure that all alleged violations including maltreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the OHFC/ CEP as required and that all allegations are thoroughly investigated. **b) Social Services will receive notifications of all grievances and assure the process of reporting, follow up and investigation as needed is taken.**	

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	245227	MLTPE BLDG	10/26/2012

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	Continued From page 9		3. Reoccurrence will be prevented by:	
F 226	10/15/12, indicated R74 was cognitively intact, required extensive assistance with bed mobility and transfers, was occasionally incontinent of bladder, and always incontinent of bowel. The Plan of Care dated April, 2012, indicated R74 required full body mechanical lift and assist of two persons for transfers. R74 requested repositioning at night and staff were to offer repositioning every 2 hours and pm (as needed). Staff to encourage R74 to use call light to notify staff of need to void and to keep the call light within reach. Nursing assistant charting from 6/15/12, indicated R74 was seen every two hours but lacked specifics as to what cares were provided. Interview with social worker (SW)-F and the Interim Director of Nursing (IDON) on 10/25/12, at 1:30 p.m. indicated they investigated R74's statement by talking with other alert residents on the unit (all of whom stated their care was provided) and by reviewing the group sheets (nurse aide documentation) showing the care was provided to R74. Although' R74 was cognitively intact, they were not interviewed as part of the investigation. The IDON stated the grievance should have been immediately reported to the administrator and the state agency. 483.20(d)(3), 483.10(k)(2) RIGHT TO	F 226	a) All Bayshore staff will be educated on the Resident Grievance Policy. b) All Bayshore staff will be educated on the Vulnerable Adult Reporting responsibilities. c) All Bayshore staff will be re-in serviced on Abuse Prevention Plan for MN SNFs **d) Reoccurrences will be managed by keeping a record of all grievances to ensure proper processing and follow up at which time any staff not following with process for processing grievances will be educated independently and or disciplined appropriately.** **e) Revision of the Grievance Policy to include notifications to DON, administration, and prompt to report to OHFC/CEP as required immediately then followed by thorough investigation.** 4. The Correction will be monitored by: a) DON, Nurse Managers and Social Services.	
F 280 SS=D	PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	5. Date of completion: 12/7/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UTH, MN.WNG	MDHE BWNG AUDC	10126/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	DULUTH, MN 55802
1601 ST LOUIS AVENUE	

(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 280	Continued From page 10 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not revise the care plan for 1 of 21 residents (R170) reviewed for pain and Findings include: R170 had complaints of hand pain and the care plan was not revised to address the pain in his hands. R170 had multiple diagnoses including end stage congestive heart failure (CHF) and peripheral neuropathy. R170 was receiving hospice services. The quarterly pain assessment on 9/26/12, indicated R170 had no complaints of pain but could verbalize pain if he had pain. On 10/23/12 at 9:50 a.m. R170 stated his hands often hurt him and had for "several months". R170 acknowledged receiving medication for the pain but stated the medication doesn't provide	shairgaistrue F 280	F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISED CP 1. Corrective Action: a) Resident R170's plan of care **was revised immediately** and updated with preferences of facial hair frequency removal. b) Resident R170's pain assessment and plan of care **was revised immediately** and updated. 2. Corrective Action as it applies to other clients: a) 100% audit of all pain assessments to ensure no client has unresolved pain thru interview **of all interviewable clients and thru direct care observation for those who are nonverbal for signs of unmanaged pain.** b) 100 % audit of all pain management plans of care to ensure all assessment findings are included in treatment plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	BLDG _____ WING _____	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	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 280	Continued From page 11 relief. R170's care plan dated 1/17/12, identified an alteration in comfort related to end stage CHF and identified that he denied pain. The care plan contained some generic approaches for pain such as assessing characteristics of pain and medicating per MD order; however, there were no approaches related to management of R170's complaints of hand pain. On 10/26/12, at 10:45 a.m. Clinical Manager (CM) - A stated she remembered hearing something about that on the 24 hour report. RN-D stated she was unaware R170 was having pain. CM-A stated she would update his-pain assessment and care plan. R170 was observed to be unshaven at 6:00 p.m. on 10/22/12, 9:40 a.m. on 10/23/12, and 10:50 a.m. on 10/25/12. R170 stated on 10/25/12, at 10:50 a.m. that he preferred to be shaved and related it to his years as a military man. The care plan dated 1/17/12, identified R170 required staff assistance with all care needs; however, did not provide staff direction for shaving assistance or frequency. When interviewed on 10/26/12, at 8:00 a.m. Nursing Assistant (NA)-E was aware R170 needed to be shaved, stating since he wasn't shaved before breakfast she would shave him after breakfast. On 10/26/12, at 10:45 a.m. RN-D stated she was unaware of R170's preference was to be shaved but if that was his preference she would get it added to his care	F 280	3. Reoccurrence will be prevented by: a) All Bayshore staff will be educated on Pain Management Policy b) All Bayshore staff will be educated on Resident's Bill of Rights. **c) All care plans are to be reviewed with family and or client every quarter at care conferences and as needed with changes to plan of care.** 4. The Correction will be monitored by: a) DON, Nurse Managers and Social Services. 5. Date of completion: 12/7/12	
F 282 SS=D	plan. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MUPE BWNG ADD	10/26/2012

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(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 282	Continued From page 12 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not ensure care plans were followed for 2 of 9 residents (R170, R74) reviewed for provision of cares. Findings include: R170 did not receive a shower as directed by his plan of care. R170 had multiple diagnoses including end stage congestive heart failure (CHF) and was receiving hospice services. R170, interviewed on 10/23/12, at 9:40 a.m., stated that he was suppose to get a shower on Mondays but it had been "several weeks" since he had one and he would "really like to have a shower." During evening observations from 4:00 p.m. to 7:00 p.m. R170 was observed to not receive a shower. R170 confirmed he did not receive a shower but did receive a "sponge bath." R170's care plan dated 1/17/12 indicated staff was to assist with bathing and resident was to shower weekly. Review of the bath schedule posted at the nursing station confirmed R170 was to receive a shower on Monday evenings. The 10/3/12, quarterly assessment indicated R170 had not refused cares. Upon interview on 10/26/12 at 10:45 a.m. Clinical Manager (CM) - A and RN-D stated facility staff provide R170's	F 282	F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. Corrective Action: a) Resident R170's plan of care will be revised and updated with preferences of bathing, shower vs. sponge bath and frequency. b) Resident R74's dialysis shunt will be monitored for patency every shift immediately. 2. Corrective Action as it applies to other clients: a) 100% audit of all client's choices regarding bathing preferences and frequency. b) 100 % audit of all clients receiving hemodialysis to ensure shunt patency is monitored every shift. c) Standing Order to be set up for clients receiving dialysis to populate order to shunt patency every shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTIPLE BUILDING	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	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 282	Continued From page 13 shower unless hospice staff inform them they will do it. CM-A confirmed that upon review of the nursing assistant documentation, R170 had been getting sponge baths instead of a shower through September and October. R74's was not provided monitoring for patency of the dialysis shunt as directed by the plan of care. R74's diagnoses included stage IV chronic kidney i disease and hemodialysis. The plan of care dated 10/12, directed nursing staff to check for a positive bruit (a swishing sound heard with a stethoscope when placed over the dialysis shunt) and thrill (a vibration felt by placing one's hands on the dialysis shunt) every shift. The plan of care for hemodialysis patients provided by the dialysis facility (undated), directed nursing staff to perform access site checks by checking the bruit and pulse every shift, and to notify the dialysis unit or the nephrologist immediately if they were not present. R74 was interviewed on 10/23/12, at 12:48 p.m., and stated the nurses check his dialysis shunt for bruit and thrill when he returns from dialysis. R74 stated the nurses do not check it every shift, just 3 times a week. On 10/23/12, at 11:05 a.m., the registered nurse manager (RNM-C) stated she assumed the nurses were checking the bruit and thrill every shift, but it was not on the treatment list for the nurses to check. RNM-C stated checking for the bruit and thrill hasn't been on the treatment list since September, 2011, and she was unable to verify they had been checking.	F 282	3. Reoccurrence will be prevented by: a) All Bayshore staff will be in serviced on Hemodialysis Policy. **b) New standing orders for dialysis care will be added to the KNS system to automatically populate the order to check bruit patency anytime a client has a dialysis order to prevent omission of this assessment on every shift.** c) All staff will be inserved on how to utilize new standing orders for dialysis patients. d) All Bayshore staff will be educated on Resident's Bill of Rights. **e) Direct Care observations will occur on each shift, 3 total per day by the Team Leader, and once weekly by Nurse Manager. Direct Care Observation Audit will include but not be limited to: Proper shift to shift communication attendance, staff's knowledge regarding Abuse Prohibition. Visual direct care audits of positioning, incontinence care, transfer type, personal care delivery and needs, environment, equipment, diet, working plan of care and pain. Education/ Discipline to be provided as needed.**	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTI BLDG _____ BWNG _____	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 309	Continued From page 14 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide effective pain management for 1 of 3 residents (R170) reviewed for pain; and did not ensure patency of a dialysis shunt for 1 of 1 residents (R74) reviewed for dialysis. Findings include: R170 had ongoing complaints of pain with no relief. R170 had multiple diagnoses including end stage congestive heart failure (CHF) and peripheral neuropathy and received hospice services.] The pain assessment dated 9/26/12, indicated R170 denied pain. The skilled hospice nursing notes indicated no pain issues. The care plan dated 1/12 identified the problem of pain related to end stage CHF and contained generic approaches for pain. On 10/23/12, at 9:32 a.m. R170 stated his hands hurt. He indicated he wasn't sure why they hurt but "sometimes it's pretty bad." He acknowledged the staff gave him medicine but stated the medicine does not relieve the pain. R170 was observed to have a guarded motion with his hands, rubbing them and holding them close to	F 309	**f) Direct Care observation findings will be reviewed and addressed for compliance by Nurse Managers every week for three months to ensure compliance with Direct Care Observation Auditing and follow up with areas addressed.** 4. The Correction will be monitored by: a) DON, Nurse Managers and Social Services. 5. Date of completion: 12/7/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTIPLE BLDG BWNG	10/26/2012

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F 309	Continued From page 15 his chest. On 10/26/12, at 9:35 a.m., the nursing assistant (NA)-E stated "Oh yeah, he's always got that pain. Some days are worse than others. Sometimes his knuckles are even swollen and red. There's nothing I can really do for it. He's on hospice you know." Interdisciplinary progress notes on 10/5/12, indicated R170 complained of left hand pain from his thumb to the middle finger that "started yesterday." Nursing staff indicated they would monitor. There was no evidence of assessment or interventions provided for the pain. Notes on 10/6/12, indicated R170 was complaining of left hand pain while grasping which rated a 5/10. On 10/7/12 at 2:53 p.m. R170 complained of left hand pain and Roxanol (a narcotic pain medication) was administered. On 10/7/12 at 7:17 p.m., R170 complained of left hand pain rated 7/10 and Roxanol was again administered with pain coming down to 5/10. The left hand was slightly swollen between the thumb and index finger at that time. No assessment was documented. Review of as needed (PRN) medication administration records indicated other doses of Roxanol were given for leg pain on 10/11/12, leg pain 7/10 on 10/17/12, achy neck 7/10, and thumb pain rated 8/10 on 10/22. Clinical Manager (CM)-A, interviewed on 10/26/12, at 10:45 a.m. stated she remembered hearing something about R170's pain on the 24 hour report. RN-D stated she was unaware R170 was having pain. The facility "Pain Management" policy dated as reviewed/revised 5/11 indicated "An RN or MD is contacted to reassess a resident if PRN pain	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. Corrective Action: a) Resident R170's pain management program assessed for effective pain management. b) Resident R74's dialysis shunt will be monitored for patency every shift. 2. Corrective Action as it applies to other clients: a) 100% audit of all client's choices regarding bathing preferences and frequency. b) 100 % audit of all clients receiving hemodialysis to ensure shunt patency is monitored every shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTIPLE BUILDING	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	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 309	Continued From page 16 medication is not effective. A pharmacist may be consulted regarding medications that may contribute to ineffective pain management." The policy further indicated that "Residents with daily pain have interventions and monitoring documented at least once a shift or more often, if needed, on a pain monitoring form." R74 was not provided monitoring of the dialysis access site. R74's diagnoses included stage IV chronic kidney disease and hemodialysis. The quarterly Minimum Data Set (MDS) dated 10/15/12, indicated R74 was cognitively intact. The plan of care dated 10/12, indicated R74 received hemodialysis three times a week, and was at risk for excess bleeding due to Heparin (an anticoagulant used to decrease the clotting ability of the blood) use during hemodialysis. The plan of care directed nursing staff to check for a positive bruit (a swishing sound heard with a stethoscope when placed over the dialysis shunt) and thrill (a vibration felt by placing one's hands on the dialysis shunt) every shift. The plan of care for hemodialysis patients provided by the dialysis facility (undated), directed nursing staff to perform access site checks by checking the bruit and pulse every shift, and to notify the dialysis unit or the nephrologist immediately if they were not present. R74 was interviewed on 10/23/12, at 12:48 p.m., and stated the nurses check his dialysis shunt for bruit and thrill when he returns from dialysis. R74 stated the nurses do not check it every shift, just 3 times a week. On 10/23/12, at 11:05 a.m., the registered nurse manager (RNM-C) stated she assumed the nurses were checking the bruit and thrill every shift, but it was not on the treatment list for the	F 309	3. Reoccurrence will be prevented by: a) All Bayshore staff will be in serviced on Hemodialysis Policy. b) All Bayshore staff will be educated on Resident's Bill of Rights. c) All Bayshore staff will be in serviced on Pain Management Policy. **d) Direct Care observations will occur on each shift, 3 total per day by the Team Leader, and once weekly by Nurse Manager. Direct Care Observation Audit will include but not be limited to: Proper shift to shift communication attendance, staff's knowledge regarding Abuse Prohibition. Visual direct care audits of positioning, incontinence care, transfer type, personal care delivery and needs, environment, equipment, diet, working plan of care and pain. Education/ Discipline to be provided as needed.** **e) Direct Care observation findings will be reviewed and addressed for compliance by Nurse Managers every week for three months to ensure compliance with Direct Care Observation Auditing and follow up with areas addressed.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	BLDG _____ WING _____	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 17 nurses to check. RNM-C stated checking for the bruit and thrill hasn't been on the treatment list since September, 2011, and she was unable to verify they had been checking. RN-B was interviewed 10/23/12, at 12:57 p.m., and stated the nurses check the bruit and thrill three times a week when R74 returns from dialysis. RN-B further stated the day shift nurses would only check it if R74 finished his dialysis on their shift. On 10/23/12, at 2:45 p.m. the director of nursing (DON) was interviewed, and stated she would expect nursing to monitor the patency of the dialysis shunt by checking the bruit and thrill every shift. The facility policy and procedure on hemodialysis, revised 5/11, does not address monitoring of the dialysis shunt for patency.	F 309	4. The Correction will be monitored by: a) DON, Nurse Managers and Social Services. 5. Date of completion: 12/7/12	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 documentation review the facility did not provide appropriate bathing and grooming assistance for 1 of 3 residents (R170) reviewed for ADLs. Findings include: R170 did not receive assistance with shaving and	F 312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 1. Corrective Action: a) Resident R170 will receive assistance with shaving and showering per his preference. 2. Corrective Action as it applies to other clients: a) 100% audit of all client's choices regarding bathing preferences and frequency. b) 100 % audit of all clients dependent in cares for client choice regarding ADL assistance/care.	

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F 312	Continued From page 18 showering. R170 had multiple diagnoses including end stage congestive heart failure (CHF) and was receiving hospice services. The care plan dated 1/12 indicated R170 required assistance of one staff member for grooming and bathing (a weekly shower). R170, interviewed on 10/23/12, at 9:40 a.m., stated that he was suppose to get a shower on Mondays but it had been "several weeks" since he had one and he would "really like to have a shower." During evening observations from 4:00 p.m. to 7:00 p.m. R170 was not provided a shower, but was given a "sponge bath." R170 was also observed to be unshaven at 6:00 p.m. on 10/22/12, 9:40 a.m. on 10/23/12, and 10:50 a.m. on 10/25/12. R170 stated on 10/25/12, at 10:50 a.m. that he preferred to be shaved and related it to his years as a military man. The bath schedule posted at the nursing station indicated R170 was to receive a shower on Monday evenings. The 10/3/12, quarterly assessment indicated R170 had not refused cares. Upon interview on 10/26/12, at 10:45 a.m. Clinical Manager (CM)-A and RN-D stated facility staff provide R170's shower unless hospice staff inform them they will do it. CM-A confirmed that R170 had been getting sponge baths instead of showers through September and October. When interviewed on 10/26/12, at 8:00 a.m. Nursing Assistant (NA)-E was aware R170 needed to be shaved. On 10/26/12 at 10:45 a.m. RN-D stated she was unaware of R170's preference was to be shaved but if that was his preference she would get it added to his care plan.	F 312	3. Reoccurrence will be prevented by: a) All Bayshore staff will be educated on Resident's Bill of Rights. **b) Direct Care observations will occur on each shift, 3 total per day by the Team Leader, and once weekly by Nurse Manager. Direct Care Observation Audit will include but not be limited to: Proper shift to shift communication attendance, staff's knowledge regarding Abuse Prohibition. Visual direct care audits of positioning, incontinence care, transfer type, personal care delivery and needs, environment, equipment, diet, working plan of care and pain. Education/ Discipline to be provided as needed.** **c) Direct Care observation findings will be reviewed and addressed for compliance by Nurse Managers every week for three months to ensure compliance with Direct Care Observation Auditing and follow up with areas addressed.** 4. The Correction will be monitored by: a) DON, Nurse Managers and Social Services. 5. Date of completion: 12/7/12	

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1. Corrective Action: a) Immediate disposal of all expired medications. **b) Protocol for management of expired medications revised to include all short life expiration medications in a weekly audit tool.** 2. Corrective Action as it applies to other clients: a) 100% audit of all medications in house to ensure proper identification of opening date and expected expiration date. 3. Reoccurrence will be prevented by: a) All Bayshore staff will be educated on Thrifty White's Medications with Shortened Expiration Dates. b) All Bayshore staff will be educated on Protocol for Managing Expired Medications. c) All Bayshore staff will be educated on the Quality Assurance sign off sheet for medications with shortened expirations. d) All Bayshore staff will be educated on the storage of medication policy	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	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 431	Continued From page 20 Based on observation, interview and document review, the facility failed to dispose expired medications in 2 of 5 medication refrigerators and 1 of 9 medication carts. The outdated injectable medications in the refrigerators had the potential to affect all new admissions if they required influenza vaccine or Mantoux. The outdated inhaler had the potential to affect 1 of 32 residents (R144) on the Park Breeze unit. Findings include: On 10/22/12, at 1:00 p.m., the medication refrigerator on the Beachwalk West unit was observed to have an open vial of Tubersol (Mantoux) solution that did not have an open date or use by date. Licensed practical nurse (LPN)-B verified the vial did not have an open or use by date, and stated the Tubersol should have been discarded after 30 days. On 10/22/12, at 3:35 p.m., the medication refrigerator on the Park Breeze unit was observed to have an open vial of influenza vaccine with an open date of 4/2/12. Registered nurse (RN)-A verified the open date, and stated the vaccine should have been discarded after 28 days. The medication cart on the Park Breeze unit was observed on 10/23/12, at 9:00 a.m., and was found to have an Advair Diskus (asthma medication) inhaler with an open date of 9/18/12. RN-A verified the open date, and stated the medication was expired. The manufacturer's insert for Tubersol directs the vial to be discarded 30 days after the first use. The manufacturer's insert for the influenza vaccine directs the vial to be discarded 28 days after the first use. The manufacturer's insert for the Advair Diskus directs the inhaler be discarded 30 days after opening. The facility policy and procedure on storage of	F 431	**e) Nurse Managers will audit the refrigerators, treatment carts for medications with shortened life every two weeks along with a review of the Quality Assurance Sign off Sheet for compliance of use for the next three months to assure the protocol is being followed and is adopted.** 4. The Correction will be monitored by: a) DON, Nurse Managers 5. Date of completion: 12/7/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	MULTI BLDG	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYSHORE HEALTH CENTER	CODE 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 431	Continued From page 21 medications revised 5/2011, directs all outdated medication to be destroyed.	F 431	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	1. Corrective Action: a) 100% Audit of all clients wanting to assist in the delivery of clothing protectors will be assessed, educated and care planned for the ability to perform task and maintain infection control practice. **R191 has discharged.** b) All staff to provide hand sanitation prior to all meals. 2. Corrective Action as it applies to other clients: a) Any client currently assisting in the delivery of clothing protectors will be assessed, educated and care planned for the ability to perform task and maintain infection control practice. b) Implementation of a policy for Resident Volunteer – Passing of clothing protectors by activity department. c) All staff to provide hand sanitation prior to all meals.	

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	245227	MULTIPLE BLDG	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

(X4) ID PREFIX TAG	(X1) 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 441	Continued From page 22 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control procedures during distribution of clean clothing protectors to 20 of 33 residents in the first floor dining room prior to meal service; in addition, 20 of 33 residents were not offered the opportunity to cleanse their hands prior to meal service in the first floor dining room. Findings include: On 10/22/12, at 5:15 p.m., 13 residents were observed in the first floor dining room and additional residents continued to enter the dining room prior to the meal service. R191 was observed wearing a visibly soiled winter jacket, and carrying a plastic bag containing clothing protectors. As residents were entering the dining room and taking their place at the tables, R191 walked over to them, set the plastic bag on the floor, and took out a clean clothing protector to give to each resident. R191 continued to do this until 5:22 p.m., when he placed the plastic bag into a green plastic container sitting on the dining room floor. As residents continued to enter the dining room, R191 walked over to the container, retrieved a clothing protector out of the plastic bag, and brought it to the resident. R191's diagnoses included traumatic brain injury and schizophrenia. The quarterly Minimum Data Set (MDS), dated 9/28/12, indicated R191 had moderate cognitive impairment. On 10/23/12, at 12:34 p.m., the interim director of nursing (DON) was interviewed and stated staff	F 441	3. Reoccurrence will be prevented by: a) 100% audit of all clients currently assisting in the delivery of clothing protectors will be assessed, educated and care planned for the ability to perform task and maintain infection control practice. b) All Bayshore staff will be educated on Policy for Resident Volunteer – Passing of clothing protectors. **c) All meals in one day (breakfast/ lunch and dinner) will be audited twice a week for the use of sanitizing wipes for three months commencing immediately.** **d) Audits will be summarized at the end of each month for evaluation of compliance.** **e) Immediate Education will be provided to staff members not following protocol for hand sanitation prior to meals.** f)) All staff will be re-in serviced on TIPS for successful Meal Pass. 4. The Correction will be monitored by: a) DON, Nurse Managers and Activity Department 5. Date of completion: 12/7/12	

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F 441	Continued From page 23 was unaware R191 was passing clean clothing protectors to residents in the dining room. The DON stated the facility should have completed an assessment to determine if R191 could distribute clean linen while infection control standards were maintained. On 10/22/12, at 5:15 p.m., 13 residents were observed in the first floor dining room. Prior to the start of the meal service at 5:50 p.m., 20 additional residents entered the dining room. None of the 20 residents who entered the dining room after 5:15 p.m. were offered hand washing prior to the meal. On 10/23/12, at 2:45 p.m., the director of nursing (DON) stated she would expect all residents would be offered hand washing prior to meals. The facility Tips for a Successful Meal Pass, dated October, 2012, indicated all resident's hands are to be sanitized prior to the meal service.	F 441		

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

F5227022

PRINTED: 11/07/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	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. At the time of this survey Bayshore Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-Tags) TO: Health Care Fire Inspections State Fire Marshal Division 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	Facility Plan Of Correction is as follows: 1). Installation of fire alarms within 5 feet of doors held open magnetically was completed on 11/1/2012 by ESC systems in the following Locations: PT & OT room on the ground level, and both dining rooms located on the south wing on the second level. In addition the first level south wing dining room was checked and had a smoke alarm installed per LSC requirements. 2). This LSC correction was completed on 11/1/2012. 3). This correction was initiated by Justin Gervais, Environmental Services Director and he will continue to monitor the facility to prevent a reoccurrence. Environmental Services Director 11/20/2012	

DC: 12.05.2012

EXIT: 10.26.2012

POC ok 11-26-12

RECEIVED
NOV 26 2012
MINNESOTA DEPARTMENT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

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	10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

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K 000	Continued From page 1 By E-Mail to: Barbara.lundberg@state.mn.us, and Marian.whitney@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 160 beds and had a census of 133 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052 SS=D	Continued From page 2 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72. This deficient practice could affect all patients. Findings include: Based on observation during the facility tour on 10-25-12 between 9:00-10:00 AM, it was observed that doors are being held open with electric magnetice dvices and they do not have a fire alarm connected smoke detector withn 5 feet of the door opening. Two of the noted locations were, on the second level, end of south corridor both dining rooms, and the OT & PT room on the ground level. These deficient practices were verified by the Director of Facility Services at the time of the inspection.	K 052		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8809

November 7, 2012

Ms. Susan Koivisto, Administrator
Bayshore Health Center
1601 St Louis Avenue
Duluth, Minnesota 55802

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5227023

Dear Ms. Koivisto:

The above facility was surveyed on October 22, 2012 through October 26, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 11 East Superior Street, Suite 290, Duluth, Minnesota 55802. 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 me.

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,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00589	A. BUILDING _____ B. WING _____	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE HEALTH CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/22/2012 through 10/26/2012, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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	

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2 000	Continued From page 1 Certification Program; Duluth Technology Village, 11 East Superior Street, Suite 290 Duluth, MN 55802.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review the facility did not ensure care plans were followed for	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 2 2 of 9 residents (R170, R74) reviewed for provision of cares. Findings include: R170 did not receive a shower as directed by his plan of care. R170 had multiple diagnoses including end stage congestive heart failure (CHF) and was receiving hospice services. R170, interviewed on 10/23/12, at 9:40 a.m., stated that he was suppose to get a shower on Mondays but it had been "several weeks" since he had one and he would "really like to have a shower." During evening observations from 4:00 p.m. to 7:00 p.m. R170 was observed to not receive a shower. R170 confirmed he did not receive a shower but did receive a "sponge bath." R170's care plan dated 1/17/12 indicated staff was to assist with bathing and resident was to shower weekly. Review of the bath schedule posted at the nursing station confirmed R170 was to receive a shower on Monday evenings. The 10/3/12, quarterly assessment indicated R170 had not refused cares. Upon interview on 10/26/12 at 10:45 a.m. Clinical Manager (CM) - A and RN-D stated facility staff provide R170's shower unless hospice staff inform them they will do it. CM-A confirmed that upon review of the nursing assistant documentation, R170 had been getting sponge baths instead of a shower through September and October. R74's was not provided monitoring for patency of the dialysis shunt as directed by the plan of care. R74's diagnoses included stage IV chronic kidney disease and hemodialysis. The plan of care dated 10/12, directed nursing staff to check for a	2 565		

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2 565	Continued From page 3 positive bruit (a swishing sound heard with a stethoscope when placed over the dialysis shunt) and thrill (a vibration felt by placing one's hands on the dialysis shunt) every shift. The plan of care for hemodialysis patients provided by the dialysis facility (undated), directed nursing staff to perform access site checks by checking the bruit and pulse every shift, and to notify the dialysis unit or the nephrologist immediately if they were not present. R74 was interviewed on 10/23/12, at 12:48 p.m., and stated the nurses check his dialysis shunt for bruit and thrill when he returns from dialysis. R74 stated the nurses do not check it every shift, just 3 times a week. On 10/23/12, at 11:05 a.m., the registered nurse manager (RNM-C) stated she assumed the nurses were checking the bruit and thrill every shift, but it was not on the treatment list for the nurses to check. RNM-C stated checking for the bruit and thrill hasn't been on the treatment list since September, 2011, and she was unable to verify they had been checking. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could educate all appropriate staff to ensure the written comprehensive care plans are followed by all staff, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 4 individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not provide effective pain management for 1 of 3 residents (R170) reviewed for pain; and did not ensure patency of a dialysis shunt for 1 of 1 residents (R74) reviewed for dialysis. Findings include: R170 had ongoing complaints of pain with no relief. R170 had multiple diagnoses including end stage congestive heart failure (CHF) and peripheral neuropathy and received hospice services.] The pain assessment dated 9/26/12, indicated R170 denied pain. The skilled hospice nursing notes indicated no pain issues. The care plan dated 1/12 identified the problem of pain related to end stage CHF and contained generic approaches for pain. On 10/23/12, at 9:32 a.m. R170 stated his hands hurt. He indicated he wasn't sure why they hurt but "sometimes it's pretty bad." He acknowledged the staff gave him medicine but stated the	2 830		

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	00589	A. BUILDING _____ B. WING _____	10/26/2012

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2 830	Continued From page 5 medicine does not relieve the pain. R170 was observed to have a guarded motion with his hands, rubbing them and holding them close to his chest. On 10/26/12, at 9:35 a.m., the nursing assistant (NA)-E stated "Oh yeah, he's always got that pain. Some days are worse than others. Sometimes his knuckles are even swollen and red. There's nothing I can really do for it. He's on hospice you know." Interdisciplinary progress notes on 10/5/12, indicated R170 complained of left hand pain from his thumb to the middle finger that "started yesterday." Nursing staff indicated they would monitor. There was no evidence of assessment or interventions provided for the pain. Notes on 10/6/12, indicated R170 was complaining of left hand pain while grasping which rated a 5/10. On 10/7/12 at 2:53 p.m. R170 complained of left hand pain and Roxanol (a narcotic pain medication) was administered. On 10/7/12 at 7:17 p.m., R170 complained of left hand pain rated 7/10 and Roxanol was again administered with pain coming down to 5/10. The left hand was slightly swollen between the thumb and index finger at that time. No assessment was documented. Review of as needed (PRN) medication administration records indicated other doses of Roxanol were given for leg pain on 10/11/12, leg pain 7/10 on 10/17/12, achy neck 7/10, and thumb pain rated 8/10 on 10/22. Clinical Manager (CM)-A, interviewed on 10/26/12, at 10:45 a.m. stated she remembered hearing something about R170's pain on the 24 hour report. RN-D stated she was unaware R170 was having pain. The facility "Pain Management" policy dated as reviewed/revised 5/11 indicated "An RN or MD is	2 830		

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2 830	Continued From page 6 contacted to reassess a resident if PRN pain medication is not effective. A pharmacist may be consulted regarding medications that may contribute to ineffective pain management." The policy further indicated that "Residents with daily pain have interventions and monitoring documented at least once a shift or more often, if needed, on a pain monitoring form." R74 was not provided monitoring of the dialysis access site. R74's diagnoses included stage IV chronic kidney disease and hemodialysis. The quarterly Minimum Data Set (MDS) dated 10/15/12, indicated R74 was cognitively intact. The plan of care dated 10/12, indicated R74 received hemodialysis three times a week, and was at risk for excess bleeding due to Heparin (an anticoagulant used to decrease the clotting ability of the blood) use during hemodialysis. The plan of care directed nursing staff to check for a positive bruit (a swishing sound heard with a stethoscope when placed over the dialysis shunt) and thrill (a vibration felt by placing one's hands on the dialysis shunt) every shift. The plan of care for hemodialysis patients provided by the dialysis facility (undated), directed nursing staff to perform access site checks by checking the bruit and pulse every shift, and to notify the dialysis unit or the nephrologist immediately if they were not present. R74 was interviewed on 10/23/12, at 12:48 p.m., and stated the nurses check his dialysis shunt for bruit and thrill when he returns from dialysis. R74 stated the nurses do not check it every shift, just 3 times a week. On 10/23/12, at 11:05 a.m., the registered nurse manager (RNM-C) stated she assumed the nurses were checking the bruit and thrill every shift, but it was not on the treatment list for the	2 830		

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2 830	Continued From page 7 nurses to check. RNM-C stated checking for the bruit and thrill hasn't been on the treatment list since September, 2011, and she was unable to verify they had been checking. RN-B was interviewed 10/23/12, at 12:57 p.m., and stated the nurses check the bruit and thrill three times a week when R74 returns from dialysis. RN-B further stated the day shift nurses would only check it if R74 finished his dialysis on their shift. On 10/23/12, at 2:45 p.m. the director of nursing (DON) was interviewed, and stated she would expect nursing to monitor the patency of the dialysis shunt by checking the bruit and thrill every shift. The facility policy and procedure on hemodialysis, revised 5/11, does not address monitoring of the dialysis shunt for patency. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review and/or revise policies and procedures to ensure all residents are provided proper pain management and staff are trained to check dialysis residents for patency of the shunt. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 840		

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2 840	Continued From page 8 adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation review the facility did not provide appropriate bathing and grooming assistance for 1 of 3 residents (R170) reviewed for ADLs. Findings include: R170 did not receive assistance with shaving and showering. R170 had multiple diagnoses including end stage congestive heart failure (CHF) and was receiving hospice services. The care plan dated 1/12 indicated R170 required assistance of one staff member for grooming and bathing (a weekly shower). R170, interviewed on 10/23/12, at 9:40 a.m., stated that he was suppose to get a shower on Mondays but it had been "several weeks" since he had one and he would "really like to have a shower." During evening observations from 4:00 p.m. to 7:00 p.m. R170 was not provided a shower, but was given a "sponge bath." R170 was also observed to be unshaven at 6:00 p.m. on 10/22/12, 9:40 a.m. on 10/23/12, and 10:50 a.m. on 10/25/12. R170 stated on 10/25/12, at 10:50 a.m. that he preferred to be shaved and related it to his years as a military man. The bath schedule posted at the nursing station indicated R170 was to receive a shower on Monday evenings. The 10/3/12, quarterly assessment indicated R170 had not refused cares. Upon interview on 10/26/12, at 10:45 a.m. Clinical Manager (CM)-A and RN-D stated facility staff provide R170's shower unless hospice staff	2 840		

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2 840	Continued From page 10 inform them they will do it. CM-A confirmed that R170 had been getting sponge baths instead of showers through September and October. When interviewed on 10/26/12, at 8:00 a.m. Nursing Assistant (NA)-E was aware R170 needed to be shaved. On 10/26/12 at 10:45 a.m. RN-D stated she was unaware of R170's preference was to be shaved but if that was his preference she would get it added to his care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents receive showers/bathing services based on their assessed needs. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 840		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation review the facility did not provide appropriate bathing and grooming assistance for 1 of 3 residents (R170) reviewed for ADLs.	2 850		

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2 850	Continued From page 11 Findings include: R170 did not receive assistance with shaving and showering. R170 had multiple diagnoses including end stage congestive heart failure (CHF) and was receiving hospice services. The care plan dated 1/12 indicated R170 required assistance of one staff member for grooming and bathing (a weekly shower). R170, interviewed on 10/23/12, at 9:40 a.m., stated that he was suppose to get a shower on Mondays but it had been "several weeks" since he had one and he would "really like to have a shower." During evening observations from 4:00 p.m. to 7:00 p.m. R170 was not provided a shower, but was given a "sponge bath." R170 was also observed to be unshaven at 6:00 p.m. on 10/22/12, 9:40 a.m. on 10/23/12, and 10:50 a.m. on 10/25/12. R170 stated on 10/25/12, at 10:50 a.m. that he preferred to be shaved and related it to his years as a military man. The bath schedule posted at the nursing station indicated R170 was to receive a shower on Monday evenings. The 10/3/12, quarterly assessment indicated R170 had not refused cares. Upon interview on 10/26/12, at 10:45 a.m. Clinical Manager (CM)-A and RN-D stated facility staff provide R170's shower unless hospice staff inform them they will do it. CM-A confirmed that R170 had been getting sponge baths instead of showers through September and October. When interviewed on 10/26/12, at 8:00 a.m. Nursing Assistant (NA)-E was aware R170 needed to be shaved. On 10/26/12 at 10:45 a.m. RN-D stated she was unaware of R170's preference was to be	2 850		

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2 850	Continued From page 12 shaved but if that was his preference she would get it added to his care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents receive shaving services based on their assessed needs. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 850		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control procedures during distribution of clean clothing protectors to 20 of 33 residents in the first floor dining room prior to meal service; in addition, 20 of 33 residents were not offered the opportunity to cleanse their hands prior to meal service in the first floor dining room. Findings include: On 10/22/12, at 5:15 p.m., 13 residents were observed in the first floor dining room and	21385		

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21385	Continued From page 13 additional residents continued to enter the dining room prior to the meal service. R191 was observed wearing a visibly soiled winter jacket, and carrying a plastic bag containing clothing protectors. As residents were entering the dining room and taking their place at the tables, R191 walked over to them, set the plastic bag on the floor, and took out a clean clothing protector to give to each resident. R191 continued to do this until 5:22 p.m., when he placed the plastic bag into a green plastic container sitting on the dining room floor. As residents continued to enter the dining room, R191 walked over to the container, retrieved a clothing protector out of the plastic bag, and brought it to the resident. R191's diagnoses included traumatic brain injury and schizophrenia. The quarterly Minimum Data Set (MDS), dated 9/28/12, indicated R191 had moderate cognitive impairment. On 10/23/12, at 12:34 p.m., the interim director of nursing (DON) was interviewed and stated staff was unaware R191 was passing clean clothing protectors to residents in the dining room. The DON stated the facility should have completed an assessment to determine if R191 could distribute clean linen while infection control standards were maintained. On 10/22/12, at 5:15 p.m., 13 residents were observed in the first floor dining room. Prior to the start of the meal service at 5:50 p.m., 20 additional residents entered the dining room. None of the 20 residents who entered the dining room after 5:15 p.m. were offered hand washing prior to the meal. On 10/23/12, at 2:45 p.m., the director of nursing (DON) stated she would expect all residents would be offered hand washing prior to meals. The facility Tips for a Successful Meal Pass, dated October, 2012, indicated all resident's hands are to be sanitized prior to the meal	21385		

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21385	Continued From page 14 service. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee(s) could update the infection control policy and train staff on the policies. The DON or designee(s) could audit to assure the infection control policies are being implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21385		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to dispose expired medications in 2 of 5 medication refrigerators and 1 of 9 medication carts. The outdated injectable medications in the refrigerators had the potential to affect all new admissions if they required influenza vaccine or Mantoux. The outdated inhaler had the potential to affect 1 of 32 residents (R144) on the Park Breeze unit. Findings include: On 10/22/12, at 1:00 p.m., the medication refrigerator on the Beachwalk West unit was observed to have an open vial of Tubersol (Mantoux) solution that did not have an open date or use by date. Licensed practical nurse (LPN)-B	21615		

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21615	Continued From page 15 verified the vial did not have an open or use by date, and stated the Tubersol should have been discarded after 30 days. On 10/22/12, at 3:35 p.m., the medication refrigerator on the Park Breeze unit was observed to have an open vial of influenza vaccine with an open date of 4/2/12. Registered nurse (RN)-A verified the open date, and stated the vaccine should have been discarded after 28 days. The medication cart on the Park Breeze unit was observed on 10/23/12, at 9:00 a.m., and was found to have an Advair Diskus (asthma medication) inhaler with an open date of 9/18/12. RN-A verified the open date, and stated the medication was expired. The manufacturer's insert for Tubersol directs the vial to be discarded 30 days after the first use. The manufacturer's insert for the influenza vaccine directs the vial to be discarded 28 days after the first use. The manufacturer's insert for the Advair Diskus directs the inhaler be discarded 30 days after opening. The facility policy and procedure on storage of medications revised 5/2011, directs all outdated medication to be destroyed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee(s) may review or revise policies and procedures, provide an in-service in regard to these policies and procedures, and conduct audits to ensure the policies and procedures are being implemented. The DON or desigee(s) can do audits to assure expired medications are removed from the medication carts. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21615		

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21880	Continued From page 16	21880		
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 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	21880		

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21880	Continued From page 17 requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility did not address grievances for 1 of 9 residents (R164) reviewed for abuse prohibition. Findings include: R164 filed a grievance regarding not getting enough food to eat at breakfast. During the survey R164 was denied his request for more eggs. The nutritional care area assessment (CAA) dated 4/9/12, indicated R164's intake ranged from 50-75% at meals and he was at risk for developing nutritional and hydration concerns. The assessment also indicated staff would honor R164's preferences to promote weight stability. The quarterly Minimum Data Set (MDS) dated 9/26/12, indicated R164's cognition was intact. The nutritional care plan dated 8/2/12, indicated R164 had potential for alteration in nutrition and hydration. The care plan directed staff to assure R164 received double portions at meals as he frequently requested extra portions, but sometimes forgets to ask, then later becomes upset that he didn't receive extra food. The interventions on the care plan included to honor R164's preferences and offer alternatives for food refusals and double portions as agreed upon with R164 and his family.	21880		

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	00589	A. BUILDING _____ B. WING _____	10/26/2012

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21880	Continued From page 18 On 8/29/12, R164 filed a grievance with the Social Worker (SW)A, stating the kitchen was not making enough eggs for breakfast and that he would like more. The Dietary Service Director (DSD)'s typed note dated 8/30/12, indicated R164 received double portions at breakfast per his request. However, the cook had thrown out the eggs before R164 requested more. The DSD note indicated R164 was directed to ask for more food when he received his plate or before the dietary server left the dining room. R164 filed another grievance with SW-A on 10/15/12. R164 reported that a staff member took away one of his two milk servings because he didn't drink the second milk the day before. R164 wanted two milk servings at his meals. Attached to the grievance form was an undated response from SW-A that indicated the staff member had been spoken to; however, there was no evidence of a response to R164. On 10/24/12, at 9:00 a.m., R164 approached the surveyor in the main dining room and asked if there was a law against getting more eggs if someone wants more to eat. R164 stated he was told he could not have any more eggs even though he was still hungry. The cook was interviewed at this time and stated,"per the policy those residents who request double portions only get the double portions that's what I was told." The dietary supervisor (DS) was interviewed on 10/24/12, at 9:10 a.m. and stated they have a policy that indicates residents who receive double portions are to speak directly to the dietary supervisor if they want more food. The DS stated she had talked to R164 in the past regarding wanting more than double portions and instructed him to ask for a "snack" at the nurses station. The	21880		

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21880	Continued From page 19 DS stated she was not aware of R164's grievance from 10/15/12, regarding not getting 2 milks per his request. The policy titled Resident Grievances with a reviewed/revised date of 3/17/11, indicated all grievances will be submitted to the appropriate department manager and a copy will be sent to social services for review. The policy also stated all grievances will be responded to promptly (within 5 days) and followed up with the responsible party. Although social services had received the grievance, the DS had not, and R164 was not provided resolution regarding the milk grievance. SUGGESTED METHOD OF CORRECTION: The Licensed Social Workers (LSW's) or designee(s) could review and revise policies and procedures to ensure all resident/family complaints are addressed in a timely manner, investigated, and followed up on with the resident/family. The LSW's or designee(s) could educate all appropriate staff on the policies and procedures (including reporting any resident or family complaints/issues), and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21880		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in	21942		

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21942	Continued From page 20 participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: MN Stat 144A.10 Subd 8b Based on interview, the facility failed to attempt to form a family council within the past year. This had the ability to affect all residents residing in the facility. Findings include: On 10/23/12, at 11:09 a.m., the acting administrator was interviewed and stated the last family council meeting was held on 6/24/11, and the facility had not attempted to form a family council since that time. SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common	21990		

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21990	Continued From page 21 entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify, report and investigate incidents of potential mistreatment for 2 of 5 residents (R121, R74) who were reviewed for abuse prohibition. Findings include: R121's report of rough treatment by staff was not immediately reported to the administrator or state agency, and was not investigated to determine potential mistreatment. A grievance /complaint form dated 9/6/12, was completed by a registered nurse (RN) on behalf of R121 with the chief investigator identified as licensed social worker (LSW)-G. The description of the incident is as follows: The nurse practitioner (NP) called to report that R121 stated he gets a sore on his bottom when sitting for long periods of time and that some staff at Bayshore are "too rough" with him when pulling his pants	21990		

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21990	Continued From page 22 up. R121 also stated it's only certain staff and that others were "very good". LSW-G signed and dated the document as reviewed on 9/7/12. The Administrator signed and dated it as reviewed on 9/24/12. LSW-G's late entry progress note dated for 9/7/12, indicated she talked with R121 who stated staff were rough when pulling up his pants, hurting his coccyx pressure ulcer. LSW-G encouraged R121 to tell staff "ouch, stop!" or in some manner let staff know that it indeed hurt him. A memo dated 9/10/12, was placed on the nursing unit to notify staff about the proper care when pulling up R121's pants and to stop when signs and symptoms of discomfort were observed. R121's diagnoses included end stage renal disease, congestive heart disease (CHF), and 2 stage 2 coccyx pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer). The 5-day Minimum Data Set (MDS) dated 10/12/12, indicated R121 had intact cognition and needed extensive assistance with activities of daily living (ADLs).The care plan dated 9/10/12, identified R121 had an ulcer to his coccyx. Interventions included personal care assistance in a mindful manner related to potential pain to the coccyx site. Stop if signs and symptoms of pain are noted/verbalized. Pull pants up by pulling over the ulcer to decrease friction/contact to the site. R74's report of lack of personal care during the night was not reported or investigated to determine potential mistreatment. R74's Grievance/Complaint Documentation and Follow-up Report dated 6/15/12, indicated a lack of care during the night.	21990		

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21990	Continued From page 23 R74's diagnoses include generalized muscle weakness, secondary hyperparathyroidism, osteopenia, osteomyelitis, diabetes mellitus type 2, peripheral neuropathy, morbid obesity, affective psychosis, major depressive disorder, anxiety, Parkinson's disease, restless leg syndrome, blindness, congestive heart failure, stasis dermatitis, renal failure, chronic kidney disease, severe osteoarthritis and insomnia. The Quarterly Minimum Data Set (MDS) dated 10/15/12, indicated R74 was cognitively intact, required extensive assistance with bed mobility and transfers, was occasionally incontinent of bladder, and always incontinent of bowel. The Plan of Care dated April, 2012, indicated R74 required full body mechanical lift and assist of two persons for transfers. R74 requested repositioning at night and staff were to offer repositioning every 2 hours and prn (as needed). Staff to encourage R74 to use call light to notify staff of need to void and to keep the call light within reach. Nursing assistant charting from 6/15/12, indicated R74 was seen every two hours but lacked specifics as to what cares were provided. Interview with social worker (SW)-F and the Interim Director of Nursing (IDON) on 10/25/12, at 1:30 p.m. indicated they investigated R74's statement by talking with other alert residents on the unit (all of whom stated their care was provided) and by reviewing the group sheets (nurse aide documentation) showing the care was provided to R74. Although R74 was cognitively intact, they were not interviewed as part of the investigation. The IDON stated the grievance should have been immediately reported to the	21990		

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21990	Continued From page 24 administrator and the state agency. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21990		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse prevention policy regarding reporting and investigating incidents of potential mistreatment for 3 of 5 residents (R121, R64, R74) reviewed	21995		

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21995	Continued From page 25 for abuse prohibition. Findings include: The Abuse Prevention Plan dated 12/16/11, directed the facility professional who received a report of suspected resident mistreatment to immediately report the incident to the Administrator and state agency. The Administrator was responsible for ensuring that an internal investigation is completed and the results are reported to the state agency. R121's report of rough treatment by staff was not immediately reported to the administrator or state agency, and was not investigated to determine potential mistreatment. A grievance /complaint form dated 9/6/12, was completed by a registered nurse (RN) on behalf of R121 with the chief investigator identified as licensed social worker (LSW)-G. The description of the incident is as follows: The nurse practitioner (NP) called to report that R121 stated he gets a sore on his bottom when sitting for long periods of time and that some staff at Bayshore are "too rough" with him when pulling his pants up. R121 also stated it's only certain staff and that others were "very good". LSW-G signed and dated the document as reviewed on 9/7/12. The Administrator signed and dated it as reviewed on 9/24/12. LSW-G's late entry progress note dated for 9/7/12, indicated she talked with R121 who stated staff were rough when pulling up his pants, hurting his coccyx pressure ulcer. LSW-G encouraged R121 to tell staff "ouch, stop!" or in some manner let staff know that it indeed hurt him. A memo dated 9/10/12, was placed on the nursing unit to notify staff about the proper care when pulling up R121's pants and to stop when signs and symptoms of discomfort were observed. R121's diagnoses included end stage renal	21995		

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21995	Continued From page 26 disease, congestive heart disease (CHF), and 2 stage 2 coccyx pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer). The 5-day Minimum Data Set (MDS) dated 10/12/12, indicated R121 had intact cognition and needed extensive assistance with activities of daily living (ADLs).The care plan dated 9/10/12, identified R121 had an ulcer to his coccyx. Interventions included personal care assistance in a mindful manner related to potential pain to the coccyx site. Stop if signs and symptoms of pain are noted/verbalized. Pull pants up by pulling over the ulcer to decrease friction/contact to the site. R74's report of lack of personal care during the night was not reported or investigated to determine potential mistreatment. R74's Grievance/Complaint Documentation and Follow-up Report dated 6/15/12, indicated a lack of care during the night. R74's diagnoses include generalized muscle weakness, secondary hyperparathyroidism, osteopenia, osteomyelitis, diabetes mellitus type 2, peripheral neuropathy, morbid obesity, affective psychosis, major depressive disorder, anxiety, Parkinson's disease, restless leg syndrome, blindness, congestive heart failure, stasis dermatitis, renal failure, chronic kidney disease, severe osteoarthritis and insomnia. The Quarterly Minimum Data Set (MDS) dated 10/15/12, indicated R74 was cognitively intact, required extensive assistance with bed mobility and transfers, was occasionally incontinent of bladder, and always incontinent of bowel.	21995		

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21995	Continued From page 27 The Plan of Care dated April, 2012, indicated R74 required full body mechanical lift and assist of two persons for transfers. R74 requested repositioning at night and staff were to offer repositioning every 2 hours and prn (as needed). Staff to encourage R74 to use call light to notify staff of need to void and to keep the call light within reach. Nursing assistant charting from 6/15/12, indicated R74 was seen every two hours but lacked specifics as to what cares were provided. Interview with social worker (SW)-F and the Interim Director of Nursing (IDON) on 10/25/12, at 1:30 p.m. indicated they investigated R74's statement by talking with other alert residents on the unit (all of whom stated their care was provided) and by reviewing the group sheets (nurse aide documentation) showing the care was provided to R74. Although R74 was cognitively intact, they were not interviewed as part of the investigation. The IDON stated the grievance should have been immediately reported to the administrator and the state agency. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated.	21995		

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21995	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21995		