Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Bayshore Residence and Rehabilitation Center
1601 St. Louis Avenue
Duluth, MN 55802
St. Louis County

Report #: H5227052

Date: May 4, 2015

Date of Visit: February 3 and 4, 2015
Time of Visit: 12:30 p.m. - 4:45 p.m.
8:00 a.m. – 12:50 p.m.

By: Barbara White, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a resident was neglected when staff did not do proper assessment for fall risk and did not update the care plan. The resident fell out of his/her wheelchair, sustained a cerebral hemorrhage and subsequently died.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)

☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of the evidence, neglect occurred when staff failed to comprehensively assess a resident at a high risk for falls, and reassess the risks after each fall to develop effective interventions to reduce the risk of falls and injury. The resident sustained a head injury in a fall from the wheelchair and later died. The resident had several falls out of the wheelchair and the staff failed to assess and implement fall interventions to minimize the risk of falls.

The resident was diagnosed with dementia and a stroke which caused weakness and difficulty speaking. The resident required one staff person to assist with transfers and two staff to assist to walk short distances. A regular wheelchair without foot pedals was used by the resident to move about the locked memory care unit, an alarm was used to alert staff if the resident stood or fell from the wheelchair.

Staff interviews established that the resident was impulsive and would stand up or lunge out of the wheelchair, especially when the resident was restless or agitated. The resident would be more restless in the afternoon and evenings and had experienced several falls out of the wheelchair on the evening shift. The resident had seven falls out of the wheelchair on the evening shift in the four months before his death, and the staff failed to identify the pattern of falls to develop interventions to reduce the risk of falls.

The assessments completed prior to the falls for the resident recommended supervision when up in the wheelchair, and the care plan also noted the resident was to be observed for unsafe transfers and assisted to walk if restless. Two weeks before the resident fell, an alarmed seat belt used in the wheelchair was discontinued without other interventions added to decrease the risk of falls. The nurse manager said the seatbelt had been discontinued because the resident could not release the belt, and it was a restraint.

On the day of the final fall, the resident was in the activity room and fell out of the wheelchair striking his/her head and sustained a head injury. When staff found the resident, s/he was lying on his/her back a few feet from the wheelchair. Staff were not present and had not seen the resident fall. The resident had a swollen bump on the back of the head, and neurological checks were initiated. Three hours later, the resident was observed to be pale, drowsy, and less responsive. The resident was sent to the hospital and was diagnosed with several areas of bleeding in the brain. The resident died as a result of these injuries a few days later.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility failed to ensure the staff implemented the policy to address the resident's pattern and root cause of the falls. The facility policy dated April 2013 directed staff to identify the cause of a fall, and to perform a post fall evaluation. The policy noted that "if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant."

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s): A revisit was conducted to follow-up on deficiencies and licensing orders issued as a result of the investigation. It was found that the facility was back in compliance with federal and state regulations in April 2015.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Medication Administration Records

☒ Facility Incident Reports

☒ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☒ Care Guide

☒ Treatment Sheets

☒ Physician Progress Notes

☐ Laboratory and X-ray Reports

☒ Social Service Notes

☐ Meal Intake Records

☐ Activities Reports ☐ Weight Records

☒ Therapy and/or Ancillary Services Records ☒ Assessments

☐ Skin Assessments ☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☒ Death Certificate

☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes ☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☒ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: A history of falls

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ◉ Yes ○ No ○ N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 3

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 11

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☒ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☒ Injury
☐ Use of Equipment	☒ Transfers	☐ Incontinence
☒ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division-Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
St. Louis County Medical Examiners
Duluth City Police Department
St. Louis County Attorney
Duluth City Attorney

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	245227	A. BUILDING _____ B. WING _____	C 02/20/2015

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

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaint #H5227052. As a result, the following deficiency is issued:	F 000	This Plan of correction constitutes Bayshore Residence and Rehabilitation Center's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess and implement fall interventions to minimize the risk of falls for 1 of 3 residents (R1) who sustained injuries due to falls from the wheelchair. This resulted in actual harm when R1 sustained a head injury in a fall from the wheelchair, and later died. Findings include: Record review established R1 was diagnosed with dementia with aggressive behaviors, history of a stroke, and hypertension as noted in a physician's note dated 10/10/14. R1 had resided on the dementia locked unit. A health status note dated 10/13/14 assessed R1 to be at a high risk for falls related to psychotropic drug use, incontinence, and poor safety awareness. The interventions noted were the bed	F 323	F 323 This facility does ensure that the residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	

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

Interim Administrator 3/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 in low position and alarms. The physical therapy assessment dated 1/2/14 noted the resident had recent falls, was a high risk for falls due to impulsiveness, poor safety awareness and insight into limitations. R1 was not able to clearly verbalize wants and needs to the staff, the health status note dated 10/13/14 noted that R1 was sometimes understood and speech was garbled and unclear. Review of the progress notes revealed that R1 had ten falls from 7/5/14, until he was discharged to the hospital on 11/ 24/14. Nine of the falls occurred on the evening shift and eight of the falls the resident fell out of the wheelchair. The "Care Area Assessment" (CAA) dated 1/27/14 noted that R1 was a high risk of falls and noted the seat belt and alarms. The assessment noted that R1 should have "high visible placing while up in the wheelchair for closer monitoring" because of R1 standing up suddenly on his own. The care plan dated 11/22/14 noted that R1 was at risk of falls and had a history of falls at home and at the facility. The care plan noted that staff should anticipate R1's needs and observe for unsafe transfers and ambulation. Other interventions were to toilet every 2 hours, put call light in reach, follow the facility fall protocol. The care plan noted that staff were to check blood sugars if indicated, observe for seizure activity, and medication side effects. The care plan also noted to regularly give R1 snacks of pudding in the evenings, to assist R1 to stand up and ambulate when R1 appeared restless, and to have a non skid material on the seat of the wheelchair. The bed was to be in low position with a floor mat, and an alarm was used in the	F 323	1. Corrective Action: a. R1 was a resident in Bayshore Residence and Rehab, related to his chronic condition of dementia with aggressive behaviors, history of a stroke , History of multiple falls prior to admission, General Nonvonvul Epilepsy, COPD, Anxiety State, Anemia, Depressive Disorder, TIAs, and Hypertension - R1 resided on the secured unit. This resident was noted to be a high risk for fall on admission and continued to have falls in spite of all interventions attempted. After a fall, on 11/23/14 – approximately 1700 the resident was immediately assessed and found to be neurologically intact – Neuro checks were within normal limits, per documentation. The appropriate family and	

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F 323	Continued From page 2 bed and in the wheelchair. The care plan noted that R1 used a regular wheelchair without footrests and would propel himself short distances. Supervision of R1 while up in the wheelchair was not addressed in the care plan. The Nursing Assistant assignment sheet dated 11/26/14 noted an alarm was to be used in the wheelchair and if R1 was trying to stand repetitively, to ambulate with him as tolerated. Supervision of R1 while up in the wheelchair was not addressed. The activity calendar documenting activities provided to R1 for November 2014 was reviewed, there were no activities provided to R1 after 4 p.m. R1 would engage in activities offered, the care conference note date 11/5/14 noted R1 would take part in sensory, music, snack, and reading. The care plan dated 10/2014 noted that a Velcro self releasing seat belt was worn when in wheelchair as a fall prevention. The "Device Assessment" dated 5/10/13 for R1 noted that the belt was able to be removed by the resident, the facility did not have a more recent assessment. The care conference note on 11/5/14 reflected that the family had agreed to a trial to discontinue the seatbelt, the reason to discontinue the belt was not noted. There was no assessment on the risks and benefits of discontinuing the seatbelt on the restraint assessment dated 11/10/14, the belt was noted to be discontinued on 11/10/14. The restraint assessment dated 11/10/14 noted that the seat belt was used for unsafe mobility and during a trial of not using the belt there were no increased falls, which was not accurate. The progress notes reflected that R1 had unwitnessed falls on 11/5/14 out of bed, and on 11/8/14 at 7:15	F 323	healthcare providers were notified of the event. The resident was monitored and documented appropriately. At approximately 2200 it was reported that the resident was not himself and had changes. After the resident assessment was completed and found to be declining, the Dr. was notified and orders given for transfer the resident for emergent care. Family was notified and resident was sent to St. Luke's ER via ambulance. The ER care was completed and found that the resident had sustained a traumatic head injury. The resident received palliative care while hospitalized.	

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F 323	Continued From page 3 p.m. there was a fall when R1 tipped over the wheelchair in an unwitnessed fall in his room. These falls were not noted on the assessment for the use of the seatbelt. Progress notes and incident reports dated 11/17/14, 11/22/14, and 11/24/14 documented R1 had a series of 3 falls from the wheelchair after a velcro self releasing seatbelt was discontinued for a trial period, there was no assessment of the falls for patterns and root causes to develop interventions to reduce the risks of falls. The "Resident Incident Report" dated 11/17/14 at 4:20 p.m., R1 was unobserved in the activity room and was found on his knees next to the wheelchair with the alarm sounding, which had been in use as of the care plan dated 10/2014. There was no observed injury, a form titled "Post Fall Huddle Investigation Worksheet" noted it was not known what R1 was attempting to do when the fall occurred. No new interventions were implemented and the fall was not reviewed for a pattern of similar falls. Another fall was documented on a fall incident report dated 11/22/14 at 3:45 p.m., an aid observed R1 "lunged forward out of the wheelchair falling face first on the floor" in a lounge area. It was noted that the resident hit his head, and no injury was identified. The nurse started neurological checks and at 6:45 p.m. noted that R1 was drowsy and leaning to the left side, the physician was notified by phone and the next neurological check was normal. The "Post Fall Huddle Investigation Worksheet" was dated 11/22/14 with no new interventions added, and a pattern of falls was not reviewed.	F 323	2. <u>Corrective Action as it applies to other residents:</u> a. An audit was done of care plans and group sheets to assure that residents had been assessed for fall risk and to assure that all prevention interventions are correctly in place. b. The facility meets each business day to determine if anyone has fallen or any and all incident reports. This review process is completed using a interdisciplinary team approach. c. All residents could be considered at risk with this perceived deficient practice. 3. <u>Reoccurrence will be prevented by:</u> a. Nursing staff were re-trained on Fall Prevention Program.	

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F 323	Continued From page 4 A fall incident report dated 11/24/14 at 5 p.m., R1 had another fall out of the wheelchair. R1 was in the activity room and had an unwitnessed fall, he was found by a nursing assistant (NA) when the alarm sounded. R1 was found on his back a few feet from the wheelchair, an injury to the back of R1's head was noted, " a 3 centimeter (c.m.) by 2 c.m. abrasion". A neurological check at that time was normal. The nurse notified a family member and noted on the "Post Fall Huddle" dated 11/24/14 that there was a request from the family to put the seatbelt back in use. The nurse recommended changing the care plan and the fall risk assessments. Neurological checks were done according to facility policy and were within normal limits. The resident was given first aid and ice applied to the injury on the back of the head. The progress note dated 11/24/14 at 8 p.m., noted the NA alerted the nurse that R1 "didn't look right and wasn't himself". The nurse noted R1 was pale, non-responsive, and not moving his extremities. R1 was transported to the hospital, he was evaluated to have several subdural hematomas (bleeding in the brain). The hospital discharge summary dated 11/28/14, noted the falls R1 had resulted in three brain hemorrhages (bleeding), The resident was placed on hospice care. The resident died on 11/28/14 and the death certificate dated 11/29/14 noted the cause of death was intracerebral hemorrhage. Nursing assistant (NA)(E) was interviewed on 2/4/14 at 10:10 a.m. and was familiar with R1, NA-E stated R1 did the best during the day, but would get restless and agitated in the late afternoon. R1 would stand and try to walk from	F 323	b. License staff were re-trained on preparing an Incident and Accident Report, risk assessing, immediately modifying interventions to prevent re-occurrence. c. Nursing staff have also been re-trained on the facility Abuse and Neglect policy. d. When falls occur, the DON is notified to assure that immediate actions have been taken concerning actual or potential risk issues. e. Each resident who have actual or have the potential for falls were reviewed related to risk assessment, careplan	

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F 323	Continued From page 5 the wheelchair, but would enjoy visiting and could be distracted. NA-E stated that most of the residents on the memory unit need to have supervision for safety, and this could be difficult while giving cares in rooms and it was best to have one person available for supervision of residents on the unit. Nursing assistant (NA)(G) was interviewed on 2/9/14 at 11:45 a.m. and stated that R1 was frequently restless in the evenings. R1 would stand up unexpectedly and quickly while in the wheelchair. She stated R1 did better if involved in activities and kept busy, but there had been a decrease in activity staff in the evenings on R1's unit. The evening registered nurse (RN)(J) was interviewed on 2/10/15 at 11:10 a.m. and verified that the evening RN covered other units on the first floor besides the memory care unit, and a nurse was not on the unit at all times. The unit was staffed with 2 nursing assistants which relied on the nursing assistant assignment sheet to direct cares with residents. RN-J stated that R1 was frequently agitated on the evening shift and did better if he was occupied, would hold a baseball and would settle. RN-J was not aware of activities occurring on the memory care unit on the evening shift. RN-J had discussed with the nursing assistants to keep R1 in sight when up in the wheelchair because of suddenly standing and trying to walk. The nurse manager (RN-B) was interviewed on 2/4/15 at 10:50 a.m. and verified that there had been concern about the seatbelt in use for R1 because he was not able to release it on his own and it would be a restraint. R1 had tipped over in	F 323	adjustments, and group sheet updates. f. Content of daily morning meeting includes Risk Management – IDT involvement. Concurrent review of falls the prior 24 hours are discussed. At the time of review, recommendations are made for completed risk assessments, care plan updates, needed referrals, and decisions will be made if further actions/interventions are required. Recommendations that are made are initiated and changes are made to the unit group sheets	

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F 323	Continued From page 6 his wheelchair with the belt in place. RN-B was not aware of any substitute interventions implemented at that time to reduce the risk of R1 suddenly standing and having a fall. RN-B could not verify when the trial occurred for not using the seatbelt and if there was an assessment of the risks and benefits of using the belt. RN-B noted the process to review falls at morning stand up and at an interdisciplinary meeting should occur but was not able to verify that there had been discussion of the falls for R1, or an overall assessment of the interventions and whether they were effective to reduce the risk of falls. The facility policy for falls titled "Falls- Clinical Protocol" dated 4/13 was reviewed. The policy noted that a resident should be assessed for fall risk on admission and document risk factors. The policy directs staff to evaluate falls to identify causes of falls. The policy noted that staff should evaluate the timing of falls, identify patterns, and any underlying medical cause of falls. It is noted that if a resident continued to fall and a cause cannot be identified the nursing staff will discuss the situation with the attending physician and medical director. The interim director of nursing (DON) was interviewed on 2/12/15 at 1 p.m. and verified that the system in place at the facility to prevent falls had been identified as an issue, and a consulting agency had been in place to improve the system. She was not able to identify when the seatbelt was started for R1 or if an assessment had been completed at that time. She verified that the belt was discontinued on 11/10/14, and an assessment of the risks and benefits had not been done at that time. The DON verified that there was not a comprehensive assessment of	F 323	4. The correction will be monitored by: The above process will be monitored by the DON, Unit Managers and designees , with oversight by Nursing Home Administrator. Any variances will be immediately corrected and the activity will be reported through the monthly QA/PI team for review. 5. Date of Completion: 3/26/15	

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BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 323	Continued From page 7 the falls for R1 to identify patterns and effective interventions, there was not a review of falls to pull the information together and evaluate. She verified there had not been an assessment of the wheelchair for safety, an increase in diversional activities or supervision, a pharmacy evaluation for falls, or a medical condition identified as contributing to falls. The DON stated that the interdisciplinary team (IDT) had not been actively identifying and resolving issues with falls. The administration management consultant was interviewed on 2/4/15 at 12 p.m. and outlined the interventions that were planned for the facility and noted that falls was a main concern. There was training planned for 2/5/14 and the policy was to be updated. A major emphasis would be to have the IDT review falls and create assessments that review each fall and the root cause analysis.	F 323		

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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: A complaint investigation was conducted to investigate complaint #H5227052. As a result 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, Office of	2 000	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.	

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2 000	Continued From page 1 Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE 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.	
2 830	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 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.	2 830		

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2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to assess and implement fall interventions to minimize the risk of falls for 1 of 3 residents (R1) who sustained injuries due to falls from the wheelchair. This resulted in actual harm when R1 sustained a head injury in a fall from the wheelchair, and later died. Findings include: Record review established R1 was diagnosed with dementia with aggressive behaviors, history of a stroke, and hypertension as noted in a physician's note dated 10/10/14. R1 had resided on the dementia locked unit. A health status note dated 10/13/14 assessed R1 to be at a high risk for falls related to psychotropic drug use, incontinence, and poor safety awareness. The interventions noted were the bed in low position and alarms. The physical therapy assessment dated 1/2/14 noted the resident had recent falls, was a high risk for falls due to impulsiveness, poor safety awareness and insight into limitations. R1 was not able to clearly verbalize wants and needs to the staff, the health status note dated 10/13/14 noted that R1 was sometimes understood and speech was garbled and unclear. Review of the progress notes revealed that R1 had ten falls from 7/5/14, until he was discharged to the hospital on 11/ 24/14. Nine of the falls occurred on the evening shift and eight of the falls	2 830		

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2 830	Continued From page 3 the resident fell out of the wheelchair. The "Care Area Assessment" (CAA) dated 1/27/14 noted that R1 was a high risk of falls and noted the seat belt and alarms. The assessment noted that R1 should have "high visible placing while up in the wheelchair for closer monitoring" because of R1 standing up suddenly on his own. The care plan dated 11/22/14 noted that R1 was at risk of falls and had a history of falls at home and at the facility. The care plan noted that staff should anticipate R1's needs and observe for unsafe transfers and ambulation. Other interventions were to toilet every 2 hours, put call light in reach, follow the facility fall protocol. The care plan noted that staff were to check blood sugars if indicated, observe for seizure activity, and medication side effects. The care plan also noted to regularly give R1 snacks of pudding in the evenings, to assist R1 to stand up and ambulate when R1 appeared restless, and to have a non skid material on the seat of the wheelchair. The bed was to be in low position with a floor mat, and an alarm was used in the bed and in the wheelchair. The care plan noted that R1 used a regular wheelchair without footrests and would propel himself short distances. Supervision of R1 while up in the wheelchair was not addressed in the care plan. The Nursing Assistant assignment sheet dated 11/26/14 noted an alarm was to be used in the wheelchair and if R1 was trying to stand repetitively, to ambulate with him as tolerated. Supervision of R1 while up in the wheelchair was not addressed. The activity calendar documenting activities provided to R1 for November 2014 was reviewed, there were no activities provided to R1 after 4	2 830		

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2 830	Continued From page 4 p.m. R1 would engage in activities offered, the care conference note date 11/5/14 noted R1 would take part in sensory, music, snack, and reading. The care plan dated 10/2014 noted that a Velcro self releasing seat belt was worn when in wheelchair as a fall prevention. The "Device Assessment" dated 5/10/13 for R1 noted that the belt was able to be removed by the resident, the facility did not have a more recent assessment. The care conference note on 11/5/14 reflected that the family had agreed to a trial to discontinue the seatbelt, the reason to discontinue the belt was not noted. There was no assessment on the risks and benefits of discontinuing the seatbelt on the restraint assessment dated 11/10/14, the belt was noted to be discontinued on 11/10/14. The restraint assessment dated 11/10/14 noted that the seat belt was used for unsafe mobility and during a trial of not using the belt there were no increased falls, which was not accurate. The progress notes reflected that R1 had unwitnessed falls on 11/5/14 out of bed, and on 11/8/14 at 7:15 p.m. there was a fall when R1 tipped over the wheelchair in an unwitnessed fall in his room. These falls were not noted on the assessment for the use of the seatbelt. Progress notes and incident reports dated 11/17/14, 11/22/14, and 11/24/14 documented R1 had a series of 3 falls from the wheelchair after a velcro self releasing seatbelt was discontinued for a trial period, there was no assessment of the falls for patterns and root causes to develop interventions to reduce the risks of falls. The "Resident Incident Report" dated 11/17/14 at 4:20 p.m., R1 was unobserved in the activity room and was found on his knees next to the	2 830		

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2 830	Continued From page 5 wheelchair with the alarm sounding, which had been in use as of the care plan dated 10/2014. There was no observed injury, a form titled "Post Fall Huddle Investigation Worksheet" noted it was not known what R1 was attempting to do when the fall occurred. No new interventions were implemented and the fall was not reviewed for a pattern of similar falls. Another fall was documented on a fall incident report dated 11/22/14 at 3:45 p.m., an aid observed R1 "lunged forward out of the wheelchair falling face first on the floor" in a lounge area. It was noted that the resident hit his head, and no injury was identified. The nurse started neurological checks and at 6:45 p.m. noted that R1 was drowsy and leaning to the left side, the physician was notified by phone and the next neurological check was normal. The "Post Fall Huddle Investigation Worksheet" was dated 11/22/14 with no new interventions added, and a pattern of falls was not reviewed. A fall incident report dated 11/24/14 at 5 p.m., R1 had another fall out of the wheelchair. R1 was in the activity room and had an unwitnessed fall, he was found by a nursing assistant (NA) when the alarm sounded. R1 was found on his back a few feet from the wheelchair, an injury to the back of R1's head was noted, " a 3 centimeter (c.m.) by 2 c.m. abrasion". A neurological check at that time was normal. The nurse notified a family member and noted on the "Post Fall Huddle" dated 11/24/14 that there was a request from the family to put the seatbelt back in use. The nurse recommended changing the care plan and the fall risk assessments. Neurological checks were done according to facility policy and were within normal limits. The resident was given first aid and ice applied to the injury on the back of the head.	2 830		

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2 830	Continued From page 6 The progress note dated 11/24/14 at 8 p.m., noted the NA alerted the nurse that R1 "didn't look right and wasn't himself". The nurse noted R1 was pale, non-responsive, and not moving his extremities. R1 was transported to the hospital, he was evaluated to have several subdural hematomas (bleeding in the brain). The hospital discharge summary dated 11/28/14, noted the falls R1 had resulted in three brain hemorrhages (bleeding), The resident was placed on hospice care. The resident died on 11/28/14 and the death certificate dated 11/29/14 noted the cause of death was intracerebral hemorrhage. Nursing assistant (NA)(E) was interviewed on 2/4/14 at 10:10 a.m. and was familiar with R1, NA-E stated R1 did the best during the day, but would get restless and agitated in the late afternoon. R1 would stand and try to walk from the wheelchair, but would enjoy visiting and could be distracted. NA-E stated that most of the residents on the memory unit need to have supervision for safety, and this could be difficult while giving cares in rooms and it was best to have one person available for supervision of residents on the unit. Nursing assistant (NA)(G) was interviewed on 2/9/14 at 11:45 a.m. and stated that R1 was frequently restless in the evenings. R1 would stand up unexpectedly and quickly while in the wheelchair. She stated R1 did better if involved in activities and kept busy, but there had been a decrease in activity staff in the evenings on R1's unit. The evening registered nurse (RN)(J) was	2 830		

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2 830	Continued From page 7 interviewed on 2/10/15 at 11:10 a.m. and verified that the evening RN covered other units on the first floor besides the memory care unit, and a nurse was not on the unit at all times. The unit was staffed with 2 nursing assistants which relied on the nursing assistant assignment sheet to direct cares with residents. RN-J stated that R1 was frequently agitated on the evening shift and did better if he was occupied, would hold a baseball and would settle. RN-J was not aware of activities occurring on the memory care unit on the evening shift. RN-J had discussed with the nursing assistants to keep R1 in sight when up in the wheelchair because of suddenly standing and trying to walk. The nurse manager (RN-B) was interviewed on 2/4/15 at 10:50 a.m. and verified that there had been concern about the seatbelt in use for R1 because he was not able to release it on his own and it would be a restraint. R1 had tipped over in his wheelchair with the belt in place. RN-B was not aware of any substitute interventions implemented at that time to reduce the risk of R1 suddenly standing and having a fall. RN-B could not verify when the trial occurred for not using the seatbelt and if there was an assessment of the risks and benefits of using the belt. RN-B noted the process to review falls at morning stand up and at an interdisciplinary meeting should occur but was not able to verify that there had been discussion of the falls for R1, or an overall assessment of the interventions and whether they were effective to reduce the risk of falls. The facility policy for falls titled "Falls- Clinical Protocol" dated 4/13 was reviewed. The policy noted that a resident should be assessed for fall risk on admission and document risk factors. The policy directs staff to evaluate falls to identify	2 830		

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2 830	Continued From page 8 causes of falls. The policy noted that staff should evaluate the timing of falls, identify patterns, and any underlying medical cause of falls. It is noted that if a resident continued to fall and a cause cannot be identified the nursing staff will discuss the situation with the attending physician and medical director. The interim director of nursing (DON) was interviewed on 2/12/15 at 1 p.m. and verified that the system in place at the facility to prevent falls had been identified as an issue, and a consulting agency had been in place to improve the system. She was not able to identify when the seatbelt was started for R1 or if an assessment had been completed at that time. She verified that the belt was discontinued on 11/10/14, and an assessment of the risks and benefits had not been done at that time. The DON verified that there was not a comprehensive assessment of the falls for R1 to identify patterns and effective interventions, there was not a review of falls to pull the information together and evaluate. She verified there had not been an assessment of the wheelchair for safety, an increase in diversional activities or supervision, a pharmacy evaluation for falls, or a medical condition identified as contributing to falls. The DON stated that the interdisciplinary team (IDT) had not been actively identifying and resolving issues with falls. The administration management consultant was interviewed on 2/4/15 at 12 p.m. and outlined the interventions that were planned for the facility and noted that falls was a main concern. There was training planned for 2/5/14 and the policy was to be updated. A major emphasis would be to have the IDT review falls and create assessments that review each fall and the root cause analysis.	2 830		

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2 830	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure adequate care and supervison to all residents that have a risk of falls. In addition the Director of Nursing or designee could develop, review and/or revise policies and procedures to adequately train and ensure competency of staff performing care and supervison. The Director of Nursing could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) Days	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced	21850		

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21850	Continued From page 10 by: Based on interview and record review, the facility failed ensure one of one residents(R1) was free from maltreatment. R1 was neglected. The facility staff failed to follow policies and procedures related to falls which included assessing R1 after falls and implement adequate review, assessment and supervision. This resulted in actual harm when R1 sustained a head injury in a fall from the wheelchair, and later died. Findings include: Record review established R1 was diagnosed with dementia with aggressive behaviors, history of a stroke, and hypertension as noted in a physician's note dated 10/10/14. R1 had resided on the dementia locked unit. A health status note dated 10/13/14 assessed R1 to be at a high risk for falls related to psychotropic drug use, incontinence, and poor safety awareness. The interventions noted were the bed in low position and alarms. The physical therapy assessment dated 1/2/14 noted the resident had recent falls, was a high risk for falls due to impulsiveness, poor safety awareness and insight into limitations. R1 was not able to clearly verbalize wants and needs to the staff, the health status note dated 10/13/14 noted that R1 was sometimes understood and speech was garbled and unclear. Review of the progress notes revealed that R1 had ten falls from 7/5/14, until he was discharged to the hospital on 11/ 24/14. Nine of the falls occurred on the evening shift and eight of the falls the resident fell out of the wheelchair. The "Care Area Assessment" (CAA) dated	21850		

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21850	Continued From page 11 1/27/14 noted that R1 was a high risk of falls and noted the seat belt and alarms. The assessment noted that R1 should have "high visible placing while up in the wheelchair for closer monitoring" because of R1 standing up suddenly on his own. The care plan dated 11/22/14 noted that R1 was at risk of falls and had a history of falls at home and at the facility. The care plan noted that staff should anticipate R1's needs and observe for unsafe transfers and ambulation. Other interventions were to toilet every 2 hours, put call light in reach, follow the facility fall protocol. The care plan noted that staff were to check blood sugars if indicated, observe for seizure activity, and medication side effects. The care plan also noted to regularly give R1 snacks of pudding in the evenings, to assist R1 to stand up and ambulate when R1 appeared restless, and to have a non skid material on the seat of the wheelchair. The bed was to be in low position with a floor mat, and an alarm was used in the bed and in the wheelchair. The care plan noted that R1 used a regular wheelchair without footrests and would propel himself short distances. Supervision of R1 while up in the wheelchair was not addressed in the care plan. The Nursing Assistant assignment sheet dated 11/26/14 noted an alarm was to be used in the wheelchair and if R1 was trying to stand repetitively, to ambulate with him as tolerated. Supervision of R1 while up in the wheelchair was not addressed. The activity calendar documenting activities provided to R1 for November 2014 was reviewed, there were no activities provided to R1 after 4 p.m. R1 would engage in activities offered, the care conference note date 11/5/14 noted R1 would take part in sensory, music, snack, and	21850		

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21850	Continued From page 12 reading. The care plan dated 10/2014 noted that a Velcro self releasing seat belt was worn when in wheelchair as a fall prevention. The "Device Assessment" dated 5/10/13 for R1 noted that the belt was able to be removed by the resident, the facility did not have a more recent assessment. The care conference note on 11/5/14 reflected that the family had agreed to a trial to discontinue the seatbelt, the reason to discontinue the belt was not noted. There was no assessment on the risks and benefits of discontinuing the seatbelt on the restraint assessment dated 11/10/14, the belt was noted to be discontinued on 11/10/14. The restraint assessment dated 11/10/14 noted that the seat belt was used for unsafe mobility and during a trial of not using the belt there were no increased falls, which was not accurate. The progress notes reflected that R1 had unwitnessed falls on 11/5/14 out of bed, and on 11/8/14 at 7:15 p.m. there was a fall when R1 tipped over the wheelchair in an unwitnessed fall in his room. These falls were not noted on the assessment for the use of the seatbelt. Progress notes and incident reports dated 11/17/14, 11/22/14, and 11/24/14 documented R1 had a series of 3 falls from the wheelchair after a velcro self releasing seatbelt was discontinued for a trial period, there was no assessment of the falls for patterns and root causes to develop interventions to reduce the risks of falls. The "Resident Incident Report" dated 11/17/14 at 4:20 p.m., R1 was unobserved in the activity room and was found on his knees next to the wheelchair with the alarm sounding, which had been in use as of the care plan dated 10/2014. There was no observed injury, a form titled "Post	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00589	A. BUILDING: _____ B. WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21850	Continued From page 13 Fall Huddle Investigation Worksheet" noted it was not known what R1 was attempting to do when the fall occurred. No new interventions were implemented and the fall was not reviewed for a pattern of similar falls. Another fall was documented on a fall incident report dated 11/22/14 at 3:45 p.m., an aid observed R1 "lunged forward out of the wheelchair falling face first on the floor" in a lounge area. It was noted that the resident hit his head, and no injury was identified. The nurse started neurological checks and at 6:45 p.m. noted that R1 was drowsy and leaning to the left side, the physician was notified by phone and the next neurological check was normal. The "Post Fall Huddle Investigation Worksheet" was dated 11/22/14 with no new interventions added, and a pattern of falls was not reviewed. A fall incident report dated 11/24/14 at 5 p.m., R1 had another fall out of the wheelchair. R1 was in the activity room and had an unwitnessed fall, he was found by a nursing assistant (NA) when the alarm sounded. R1 was found on his back a few feet from the wheelchair, an injury to the back of R1's head was noted, " a 3 centimeter (c.m.) by 2 c.m. abrasion". A neurological check at that time was normal. The nurse notified a family member and noted on the "Post Fall Huddle" dated 11/24/14 that there was a request from the family to put the seatbelt back in use. The nurse recommended changing the care plan and the fall risk assessments. Neurological checks were done according to facility policy and were within normal limits. The resident was given first aid and ice applied to the injury on the back of the head. The progress note dated 11/24/14 at 8 p.m., noted the NA alerted the nurse that R1 "didn't	21850		

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21850	Continued From page 14 look right and wasn't himself". The nurse noted R1 was pale, non-responsive, and not moving his extremities. R1 was transported to the hospital, he was evaluated to have several subdural hematomas (bleeding in the brain). The hospital discharge summary dated 11/28/14, noted the falls R1 had resulted in three brain hemorrhages (bleeding), The resident was placed on hospice care. The resident died on 11/28/14 and the death certificate dated 11/29/14 noted the cause of death was intracerebral hemorrhage. Nursing assistant (NA)(E) was interviewed on 2/4/14 at 10:10 a.m. and was familiar with R1, NA-E stated R1 did the best during the day, but would get restless and agitated in the late afternoon. R1 would stand and try to walk from the wheelchair, but would enjoy visiting and could be distracted. NA-E stated that most of the residents on the memory unit need to have supervision for safety, and this could be difficult while giving cares in rooms and it was best to have one person available for supervision of residents on the unit. Nursing assistant (NA)(G) was interviewed on 2/9/14 at 11:45 a.m. and stated that R1 was frequently restless in the evenings. R1 would stand up unexpectedly and quickly while in the wheelchair. She stated R1 did better if involved in activities and kept busy, but there had been a decrease in activity staff in the evenings on R1's unit. The evening registered nurse (RN)(J) was interviewed on 2/10/15 at 11:10 a.m. and verified that the evening RN covered other units on the first floor besides the memory care unit, and a	21850		

Minnesota Department of Health

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21850	Continued From page 15 nurse was not on the unit at all times. The unit was staffed with 2 nursing assistants which relied on the nursing assistant assignment sheet to direct cares with residents. RN-J stated that R1 was frequently agitated on the evening shift and did better if he was occupied, would hold a baseball and would settle. RN-J was not aware of activities occurring on the memory care unit on the evening shift. RN-J had discussed with the nursing assistants to keep R1 in sight when up in the wheelchair because of suddenly standing and trying to walk. The nurse manager (RN-B) was interviewed on 2/4/15 at 10:50 a.m. and verified that there had been concern about the seatbelt in use for R1 because he was not able to release it on his own and it would be a restraint. R1 had tipped over in his wheelchair with the belt in place. RN-B was not aware of any substitute interventions implemented at that time to reduce the risk of R1 suddenly standing and having a fall. RN-B could not verify when the trial occurred for not using the seatbelt and if there was an assessment of the risks and benefits of using the belt. RN-B noted the process to review falls at morning stand up and at an interdisciplinary meeting should occur but was not able to verify that there had been discussion of the falls for R1, or an overall assessment of the interventions and whether they were effective to reduce the risk of falls. The facility policy for falls titled "Falls- Clinical Protocol" dated 4/13 was reviewed. The policy noted that a resident should be assessed for fall risk on admission and document risk factors. The policy directs staff to evaluate falls to identify causes of falls. The policy noted that staff should evaluate the timing of falls, identify patterns, and any underlying medical cause of falls. It is noted	21850		

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21850	Continued From page 16 that if a resident continued to fall and a cause cannot be identified the nursing staff will discuss the situation with the attending physician and medical director. The interim director of nursing (DON) was interviewed on 2/12/15 at 1 p.m. and verified that the system in place at the facility to prevent falls had been identified as an issue, and a consulting agency had been in place to improve the system. She was not able to identify when the seatbelt was started for R1 or if an assessment had been completed at that time. She verified that the belt was discontinued on 11/10/14, and an assessment of the risks and benefits had not been done at that time. The DON verified that there was not a comprehensive assessment of the falls for R1 to identify patterns and effective interventions, there was not a review of falls to pull the information together and evaluate. She verified there had not been an assessment of the wheelchair for safety, an increase in diversional activities or supervision, a pharmacy evaluation for falls, or a medical condition identified as contributing to falls. The DON stated that the interdisciplinary team (IDT) had not been actively identifying and resolving issues with falls. The administration management consultant was interviewed on 2/4/15 at 12 p.m. and outlined the interventions that were planned for the facility and noted that falls was a main concern. There was training planned for 2/5/14 and the policy was to be updated. A major emphasis would be to have the IDT review falls and create assessments that review each fall and the root cause analysis. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and	21850		

Minnesota Department of Health

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21850	Continued From page 17 procedures to ensure each resident's bill of rights are upheld and residents are free from maltreatment. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21850		

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	4/6/2015

Name of Facility	Street Address, City, State, Zip Code
BAYSHORE RESIDENCE & REHAB CTR	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 F0323 Reg. # 483.25(h) LSC	03/26/2015	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 MN/mm	Date: 04/16/2015	Signature of Surveyor: 19692	Date: 04/06/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/20/2015			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO

AH Form Approved
4/16/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00589	A. Building B. Wing	4/6/2015

Name of Facility	Street Address, City, State, Zip Code
BAYSHORE RESIDENCE & REHAB CTR	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 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 03/26/2015	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 1 LSC	Correction Completed 03/26/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MN/mm	04/16/2015	19692	04/06/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
2/20/2015

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