

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report PUBLIC

Facility: Bayshore Residen 1601 St. Louis Av Duluth, MN 5580 St. Louis County		Report #: H5227052 Date: May 4, 2015				
Time of Visit: 12	oruary 3 and 4, 2015 :30 p.m 4:45 p.m. 00 a.m. – 12:50 p.m.	By: Barbara White, R.N., Special Investigator				
<u>Type of Facility</u> :	☑ Nursing Home ☐ SLF ☐ Hospital	☐ HHA ☐ ICF/IID ☐ Other:	☐ Home Care Provider/Assisted Living ☐ Home Care			
☐ Facility Self Re	eport 🖾 Complaint					
a	is alleged that a resident was and did not update the care plan. erebral hemorrhage and subsequents	The resident fell out	did not do proper assessment for fall risk tof his/her wheelchair, sustained a			
An unannounced	visit was made at this facility	and an investigation	on 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)
Γ	State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
	State Licensing Rules for Home Care (MN Rules Chapter 4668)
Γ	State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
F	State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
~	State Statutes Chanters 144 and 144 A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

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

☐ Abuse

✓ Neglect

Financial Exploitation was:

© Substantiated C Not Substantiated C 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:

☑ Nurses Notes

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.

<u>Minnesota Statutes, section 626.5572, subdivision 17 - Neglect</u> "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	☑ Care Guide
☑ Medication Administration Records	☑ Treatment Sheets
☑ Facility Incident Reports	☑ Physician Progress Notes
☑ ADL (Activities of Daily Living) Flow Sheets	☐ Laboratory and X-ray Reports
☑ Physician Orders	☑ Social Service Notes

☐ Meal Intake Records

Bayshore Residence and Rehabilitation Center	H5227052	Page 5 of 7
☐ 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/Backg	ground Check, etc.
☑ Staff Time Sheets, Schedules, etc.	☑ Facility In-service Record	is
☑ Facility Internal Investigation Reports	☑ Facility Policies and Proc	edures
☐ 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 in-	vestigation?
C Yes ♠ No C N/A Specify: Deceased		v
Interviews: The following interviews were conduct	ted during the investigation:	
Interview with complainant(s): Yes No N	/A Specify:	
If unable to contact complainant, attempts were made Date/time: Date/time: Date/time:	on:	
Interview with family: *Yes No N/A Spe	ecify:	
Did you interview the resident(s) identified in allegation	on: Yes No N/A Spe	cify: 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 re	quired: [©] Yes C No					
Total number of staff interviews:	11					
Physician interviewed:	← No					
Nurse Practitioner interviewed:	C Yes © No					
Interview with Alleged Perpetrate	or(s): Yes No N/A Specia	ý:				
Attempts to contact: Date/time:	Date/time: Date/time	ne:				
If unable to contact was subpoena	issued: Yes , date subpoena was	issued				
Were contacts made with any of t ☐ Emergency personnel ☐ Pol	he following: ice Officers	☐ Other: Specify				
Observations were conducted re	elated 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 insp	Was any involved equipment inspected: Yes No N/A					
Was equipment being operated in safe manner:						

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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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
	•					(С
_		245227	B. WING	=		02/:	20/2015
NAME OF	ROVIDER OR SUPPLIER		ŀ		TREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAB CTR	1		501 ST LOUIS AVENUE		j
				Đ	ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 000	INITIAL COMMENT	IS	FO	000	This Plan of correction constituters Bayshore Residence and	tes	•
•	An abbreviated eta	ndard survey was conducted			Rehabilitation Center's written		
		laint #H5227052. As a result,	•				ŀ
	the following deficie				allegation of compliance for the	<u> </u>	
F 323	483.25(h) FREE OF		F3	23	deficiencies cited. However,		ļ
SS=G	HAZARDS/SUPER	VISION/DEVICES		1	submission of this Plan of Corre	ction	
	The facility must en	sure that the resident			is not an admission that a defici	ency	
		ns as free of accident hazards			exists or that one was cited corr	rectly.	
		each resident receives			This Plan of correction is submit	•	
	adequate supervisk prevent accidents.	on and assistance devices to			meet requirements established by		
	prevent accidents.				state and federal law.	- ,	
]	State Sila leachdriaw.		
					F 323		
	This REQUIREMEN	NT is not met as evidenced			This facility does ensure that the	.	1
	by:	1			residents environment remains		
		and record review, the facility implement fall interventions					
! 		of falls for 1 of 3 residents			free of accident hazards as is po		•
	(R1) who sustained	l injuries due to falls from the			and each resident receives adec	-	
		sulted in actual harm when R1			supervision and assistance device	es to	
•	sustained a пеаd in wheelchair, and late	njury in a fall from the er died			prevent accidents.		
	-	J. 4104.					
	Findings include:	·					
	1	iblished R1 was diagnosed aggressive behaviors, history			,		
		pertension as noted in a	}				
		ted 10/10/14. R1 had resided					
	on the dementia loa	cked unit.					1
	A health status not	e dated 10/13/14 assessed R1					
•	to be at a high risk	for falls related to psychotropic					
		nce, and poor safety					`
l	awareness. The inf	terventions noted were the bed			·		
LABORATOR	Y DIRECTOR'S OR PROVI	DEPASUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X5) 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 group participation.

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		AND HUMAN SERVICES		. (APPROVI 0938-03
STATEMENT	ENTERS FOR MEDICARE & MEDICAID SERVICES TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUILDING		(X3) DATE SURVEY COMPLETED			
		245227	B. WNG		02/	2 <u>0/2015</u>
	PROVIDER OR SUPPLIER RE RESIDENCE & RI	EHAB CTR	1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	BE	(X5) COMPLETIO DATE
			(:			-

F 323

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

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 Nonvonvui 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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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
-		245227	B, WING			1	C 20/2015
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F 323	that R1 used a reg footrests and would distances. Supervi wheelchair was not The Nursing Assist 11/26/14 noted an wheelchair and if Frepetitively, to amb Supervision of R1 not addressed. The activity calend provided to R1 for there were no activity p.m. R1 would encare conference in would take part in reading. The care plan date self releasing seat wheelchair as a fat Assessment date belt was able to be facility did not have the family had the seatbelt, the rewas not noted. The risks and benefits the restraint assessment was noted to be directed to be d	elchair. The care plan noted ular wheelchair without d propel himself short sion of R1 while up in the t addressed in the care plan. tant assignment sheet dated alarm was to be used in the R1 was trying to stand culate with him as tolerated, while up in the wheelchair was lar documenting activities. November 2014 was reviewed, vities provided to R1 after 4 gage in activities offered, the ote date 11/5/14 noted R1 sensory, music, snack, and led 10/2014 noted that a Velcro belt was worn when in li prevention. The "Device d 5/10/13 for R1 noted that the eremoved by the resident, the eremoved by the resident, the eremoved to a trial to discontinue eason to discontinue the belt ere was no assessment on the of discontinued on 11/10/14, the belt iscontinued on 11/10/14, the belt iscontinued on 11/10/14. The ent dated 11/10/14 noted that using the belt there were no nich was not accurate. The flected that R1 had unwitnessed to find and on 11/8/14 at 7:15.		23	healthcare providers in notified of the event. resident was monitore and documented appropriately. At approximately 2200 it reported that the resi was not himself and himself and himself and found declining, the Dr. was notified and orders gir for transfer the resident for emergent care. Far was notified and resident assessment to St. Luke's via ambulance. The limit care was completed a found that the resident had sustained a traum head injury. The resident received palliative care while hospitalized.	The ed was addent was to be went amily lent ER end ant matic dent	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
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	RE RESIDENCE & RE	LIAD CTD	İ		1691 ST LOUIS AVENUE		
BAISHO	KE KESIDENCE & KE	IIIAB OTK			DULUTH, MN 55802		
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F 323	p.m. there was a fall wheelchair in an un. These falls were no the use of the seath. Progress notes and 11/17/14, 11/22/14, had a series of 3 fall velcro self releasing a trial period, there falls for patterns and interventions to rediffer the "Resident Incide 4:20 p.m., R1 was a room and was found wheelchair with the been in use as of the There was no observed Huddle Investignot known what R1 the fall occurred. No implemented and the pattern of similar fall was do report dated 11/22/10bserved R1 "lunge wheelchair falling fallounge area. It was head, and no injury started neurological of Fall Huddle Investignost of the physician mext neurological of Fall Huddle Investignostics.	Il when R1 tipped over the witnessed fall in his room. It noted on the assessment for welt. Incident reports dated and 11/24/14 documented R1 ils from the wheelchair after a greatbelt was discontinued for was no assessment of the direct root causes to develop uce the risks of fails. In Report dated 11/17/14 at unobserved in the activity don his knees next to the alarm sounding, which had be care plan dated 10/2014. It was was attempting to do when onew interventions were a fall was not reviewed for a list of the foor in a noted that the resident hit his was identified. The nurse is checks and at 6:45 p.m. In a notified by phone and the neck was normal. The "Post pation Worksheet" was dated in the resident was dated in the resident hit his was identified. The nurse is checks and at 6:45 p.m. In own and the neck was normal. The "Post pation Worksheet" was dated	F3	323	 2. Corrective Action as it apple to other residents: a. An audit was done of complans and group sheets assure that residents have been assessed for fall reand to assure that all prevention intervention are correctly in place. b. The facility meets each business day to determ if anyone has fallen or and all incident reports. This review process is completed using a interdisciplinary team approach. c. All residents could be considered at risk with perceived deficient practice. 3. Reoccurrence will be prevented by: a. Nursing staff were retrained on Fall Preventing Program. 	are to ad isk ns nine any s.	
	11/22/14 with no ne pattern of falls was.	w interventions added, and a not reviewed.		;			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	••	2 45227	B. WING	·		0.0	C
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	·		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	//20/2015
BAYSHO	RE RESIDENCE & RE	HARCTR			1601 ST LOUIS AVENUE		
	TO THE OTHER PROPERTY.		1		DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE PROPRIES OF THE PROP	AE.	(XS) COMPLETION DATE
	A fall incident report had another fall out the activity room an was found by a nurs alarm sounded. R1 feet from the wheeld R1's head was note c.m. abrasion". A ne was normal. The nu and noted on the "Property of the seatbelt be recommended channisk assessments. No done according to fanormal limits. The reice applied to the injustice applied to	dated 11/24/14 at 5 p.m., R1 of the wheelchair. R1 was in d had an unwitnessed fall, he sing assistant (NA) when the was found on his back a few chair, an injury to the back of d, " a 3 centimeter (c.m.) by 2 curological check at that time rese notified a family member ost Fall Huddle" dated was a request from the family ack in use. The nurse ging the care plan and the fall eurological checks were icility policy and were within esident was given first aid and any on the back of the head. In the nurse that R1 "didn't thimself". The nurse noted sponsive, and not moving his transported to the hospital, have several subdural g in the brain). The resident was are. The resident died on ath certificate dated 11/29/14 eath was intracerebral IA)(E) was interviewed on and was familiar with R1, the best during the day, but	F 3	323	b. License staff were retrained on preparing a Incident and Accident Report, risk assessing, immediately modifying interventions to prevene re-occurrence. c. Nursing staff have also been re-trained on the facility Abuse and Neglipolicy. d. When falls occur, the Dis notified to assure the 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	s nt lect DON	
	afternoon. R1 would	stand and try to walk from				ľ	Ī

PRINTED: 03/13/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 245227 B. VVING 02/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 1601 ST LOUIS AVENUE BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFIC!ENCY F 323 | Continued From page 5 F 323 adjustments, and group the wheelchair, but would enjoy visiting and could be distracted. NA-E stated that most of the sheet updates. residents on the memory unit need to have f. Content of daily morning supervision for safety, and this could be difficult meeting includes Risk while giving cares in rooms and it was best to have one person available for supervision of Management - IDT residents on the unit. involvement. Concurrent review of falls the prior 24 Nursing assistant (NA)(G) was interviewed on 2/9/14 at 11:45 a.m. and stated that R1 was hours are discussed. At frequently restless in the evenings. R1 would the time of review. stand up unexpectedly and quickly while in the wheelchair. She stated R1 did better if involved in recommendations are activities and kept busy, but there had been a made for completed risk decrease in activity staff in the evenings on R1's unit assessments, care plan updates, needed referrals, The evening registered nurse (RN)(J) was and decisions will be made interviewed on 2/10/15 at 11:10 a.m. and verified that the evening RN covered other units on the if further first floor besides the memory care unit, and a actions/interventions are nurse was not on the unit at all times. The unit was staffed with 2 nursing assistants which relied required. on the nursing assistant assignment sheet to Recommendations that are direct cares with residents. RN-J stated that R1 made are initiated and was frequently agitated on the evening shift and did better if he was occupied, would hold a changes are made to the baseball and would settle. RN-J was not aware of unit group sheets 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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	DLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245227	B, WING		1	C	
NAME OF	PROVIDER OR SUPPLIER	ZTOLZ		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	/20/2015	
BAYSHORE RESIDENCE & REHAB CTR			1501 ST LOUIS AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LDBF	(X5) COMPLETION DATE	
F 323	not aware of any suimplemented at that suddenly standing a not verify when the seatbelt and if there risks and benefits of the process to revie and at an interdiscip but was not able to discussion of the fall assessment of the inwere effective to recommend that a resident risk on admission as policy directs staff to causes of falls. The evaluate the timing any underlying med that if a resident correspond to the situation with the medical director. The interim director interviewed on 2/12 the system in place had been identified agency had been in	the belt in place. RN-B was abstitute interventions time to reduce the risk of R1 and having a fall. RN-B could trial occurred for not using the was an assessment of the fusing the belt. RN-B noted we falls at morning stand up offinary meeting should occur verify that there had been also for R1, or an overall interventions and whether they duce the risk of falls. It falls titled "Falls- Clinical B was reviewed. The policy at should be assessed for fall and document risk factors. The policy noted that staff should of falls, identify patterns, and ical cause of falls. It is noted intinued to fall and a cause the nursing staff will discuss a attending physician and of nursing (DON) was 15 at 1 p.m. and verified that at the facility to prevent falls as an issue, and a consulting place to improve the system.	F3	4. The correction will be monitored by: The above process will be monitored by the DON, Managers and designee oversight by Nursing Ho Administrator. Any varia will be immediately corrand the activity will be reported through the mQA/PI team for review. 5. Date of Completion: 3/2	Unit i, with ne nces ected		
	was started for R1 completed at that tir was discontinued or assessment of the r been done at that tir	identify when the seatbelt or if an assessment had been me. She verified that the belt in 11/10/14, and arrisks and benefits had not me. The DON verified that inprehensive assessment of				,	

PRINTED: 03/13/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A, BUILI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
. •	-	 245227	B. WING			.1	/20/2015
•	PROVIDER OR SUPPLIER RE RESIDENCE & RE	ЕНАВ СТР.	·	1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID -PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	interventions, there pull the information verified there had no wheelchair for safet activities or supervifor falls, or a medic contributing to falls, interdisciplinary teal identifying and resolute the administration interviewed on 2/4/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	ge 7 lentify patterns and effective was not a review of falls to together and evaluate. She ot been an assessment of the ty, an increase in diversional sion, a pharmacy evaluation al condition identified as. The DON stated that the m (IDT) had not been actively olving issues with falls. Inanagement consultant was 15 at 12 p.m. and outlined the tere planned for the facility and a main concern. There was 2/5/14 and the policy was to or emphasis would be to have and create assessments that if the root cause analysis.	F				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00589	D. VVING		02/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	•	, ,	STATE, ZIP CODE		
BAYSHO	RE RESIDENCE & RE	HAR CTR	LOUIS AVEN , MN 55802	UE		
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2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the Minnesota Departmen	nether a violation has been				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	rule provided at the tag ille number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.	į			
	investigate complain following corrections When corrections a date, make a copy of original to the Minne	gation was conducted to nt #H5227052. As a result the		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00589	B. WING		C 02/20/2015	
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	OLIBARA DV. OTA	TEMENT OF DEFICIENCIES	MN 55802	PROVIDER'S PLAN OF CORRECTION	NN over	
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2 000	Continued From pa	ge 1	2 000			
	Health Facility Com Place, Suite 220, S 55164-0970.	iplaints; 85 East Seventh t. Paul, Minnesota,		The assigned tag number appears far left column entitled "ID Prefix The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state safter the statement, "This Rule is ras evidence by." Following the surfindings are the Suggested Method Correction and Time period for Co PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	ag." iance is of the "To order. ngs tatute tot met veyors d of rrection. DING OF THIS DON FOR	
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			
	receive nursing can custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	СОМ	E SURVEY PLETED
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2 830	by: Based on interview failed to assess and to minimize the risk (R1) who sustained wheelchair. This resustained a head in wheelchair, and late Findings include:	ent is not met as evidenced and record review, the faci d implement fall intervention of falls for 1 of 3 residents I injuries due to falls from the sulted in actual harm when njury in a fall from the	lity ns			
	with dementia with of a stroke, and hy physician's note day on the dementia look. A health status note to be at a high risk drug use, incontine awareness. The interior low position and assessment dated recent falls, was a himpulsiveness, poor into limitations. R1 verbalize wants and status note dated 1 sometimes understand unclear.	aggressive behaviors, historpertension as noted in a ted 10/10/14. R1 had reside sked unit. e dated 10/13/14 assessed for falls related to psychotronce, and poor safety erventions noted were the lalarms. The physical theraphylical theraphylical for falls due to be safety awareness and ins was not able to clearly dineeds to the staff, the head 0/13/14 noted that R1 was not and speech was garble tress notes revealed that R1	ed R1 opic bed by ad ight			
	had ten falls from 7 to the hospital on 1	/5/14, until he was discharg 1/ 24/14. Nine of the falls ening shift and eight of the f	ged			

Minnesota Department of Health

PRINTED: 03/13/2015 FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIËR/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 02/20/2015 00589 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1601 ST LOUIS AVENUE BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 Continued From page 3 2830 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

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not addressed.

repetitively, to ambulate with him as tolerated. Supervision of R1 while up in the wheelchair was

The activity calendar documenting activities provided to R1 for November 2014 was reviewed, there were no activities provided to R1 after 4

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00589 02/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1601 ST LOUIS AVENUE BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG **DEFICIENCY**) 2 830 Continued From page 4 2830 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

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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

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00589 02/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1601 ST LOUIS AVENUE BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) 2 830 Continued From page 5 2830 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

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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

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.

to put the seatbelt back in use. The nurse

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING 00589 02/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1601 ST LOUIS AVENUE BAYSHORE RESIDENCE & REHAB CTR DULUTH, MN 55802** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 830 Continued From page 6 2 830 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

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2 830	Continued From pa	age 7	2 830		
			,		
	interviewed on 2/10	0/15 at 11:10 a.m. and verified	'		
	that the evening R	N covered other units on the			
	nrst floor besides t	he memory care unit, and a			
	nurse was not on t	the unit at all times. The unit	a		
	was staffed with 2	nursing assistants which relie	"		
	on the nursing ass	sistant assignment sheet to			
	direct cares with re	esidents. RN-J stated that R1			
	was frequently agr	tated on the evening shift and			
	did better if he was	s occupied, would hold a	. F		
	baseball and would	d settle. RN-J was not aware	"		
	activities occurring	on the memory care unit on		1	
	the evening shift.	RN-J had discussed with the	_		
	nursing assistants	to keep R1 in sight when up i	id		
		cause of suddenly standing ar	ou	İ	•
	trying to walk.				
	The	er (RN-B) was interviewed on	Ì		!
	The nurse manage	m. and verified that there had			
	2/4/ 15 at 10.50 a.i	out the seatbelt in use for R1			
	been concern abo	not able to release it on his ow	n		
	pecause ne was i	restraint. R1 had tipped over i	l		
	and it would be a	h the belt in place. RN-B was	''		
1	nis wheelchair Will	substitute interventions	1		
	implemented at the	nat time to reduce the risk of R	1		
	milipiernemeu at tri	and having a fall, RN-B could	ı l		
	not verify when the	e trial occurred for not using the	ne		
	coatbalt and if the	ere was an assessment of the			i
	ricks and honofits	of using the belt. RN-B noted	1		
l	the process to rev	view falls at morning stand up			
	and at an interdisc	ciplinary meeting should occur	-		
	hut was not able t	to verify that there had been			
	discussion of the	falls for R1, or an overall			
	assessment of the	e interventions and whether th	ey		
1	were effective to	reduce the risk of falls.			
	Wele checure to	i adada ina manari			
	The facility policy	for falls titled "Falls- Clinical	}	<u> </u>	1
	Protocol" dated 4	/13 was reviewed. The policy			
	noted that a resid	lent should be assessed for fa	u		
	risk on admission	and document risk factors. T	he l		
	policy directs staf	ff to evaluate falls to identify			
	holich allects stat	I to created tone to identify	!	<u></u>	

Minnes of	a Department of He	alth		CONCERNATION	(X3) DATE S	URVEY
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2 830	Continued From pa	age 8	2 830			
2 030	_	_			ļ	
	causes of falls. The	e policy noted that staff should]			
	evaluate the timing	of falls, identify patterns, and	1		!	
	any underlying me	dical cause of falls. It is noted ontinued to fall and a cause				
	that it a resident co	d the nursing staff will discuss				
	the cituation with the	he attending physician and				
	medical director.	no attorionia priformii aria			'	
	medical director.		1			
	The interim director	or of nursing (DON) was	,			' '
	interviewed on 2/1	2/15 at 1 p.m. and verified that				
	the system in place	e at the facility to prevent falls	1			İ
	had been identified	d as an issue, and a consulting	1			
	agency had been i	in place to improve the system.	1			
	She was not able to	to identify when the seatbelt	1			
	was started for R1	or if an assessment had been	1			
	completed at that	time. She verified that the belt				
	was discontinued	on 11/10/14, and an risks and benefits had not	1			
	assessment of the	time. The DON verified that				
	there was not a co	omprehensive assessment of				
	the falls for R1 to i	identify patterns and effective				
	interventions, then	e was not a review of falls to	1			
	pull the information	n together and evaluate. She				İ
	verified there had	not been an assessment of the				
	wheelchair for safe	ety, an increase in diversional				
	activities or super	vision, a pharmacy evaluation				
	for falls, or a medi	ical condition identified as	<u> </u>			
[contributing to fall	s. The DON stated that the				i
1	interdisciplinary te	eam (IDT) had not been actively solving issues with falls.	1			
	identifying and res	OUMING ISSUES WITH ICHS.	ļ			
	The administration	n management consultant was				
	interviewed on 2/4	1/15 at 12 p.m. and outlined the				!
	interventions that	were planned for the facility and	.			i
	noted that falls wa	as a main concern. There was				
Į.	training planned for	or 2/5/14 and the policy was to				
}	be updated. A ma	ijor emphasis would be to have				
ļ	the IDT review fal	ils and create assessments that	: [
	review each fall a	nd the root cause analysis.				1

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		DOEGIII		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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2 830	Continued From pa	age 9	2 830		İ	ļ
	SUGGESTED ME	THOD OF CORRECTION:				
		rsing or designee could				
	develop, review, ar	nd/or revise policies and	!			
	procedures to ensu	ure adequate care and				
	supervison to all re	esidents that have a risk of falls	-		j	
	In addition the Dire	ector of Nursing or designee	1			
	could develop, rev	iew and/or revise policies and quately train and ensure			i	
	competency of sta	off performing care and				
	supervison. The D	irector of Nursing could				
	educate all approp	priate staff on the policies and				
	procedures. The D	Director of Nursing or designee	1 !			'
		nitoring systems to ensure				
	ongoing compliand	ce.				
	TIME DEPIOD FO	R CORRECTION: Thirty (30)			ļ	
	Days	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		į	
	24,0					
21850	MN St Statute 14	4.651 Subd. 14 Patients &	21850			
_,,,,,	Residents of HC F					
			1		;	
	Subd. 14. Freed	dom from maltreatment.			j	
	Residents shall be	e free from maltreatment as				
	defined in the Vulf	nerable Adults Protection Act. eans conduct described in				
	section 626 5572	subdivision 15, or the				
	intentional and no	n-therapeutic infliction of			!	
	physical pain or in	ijury, or any persistent course o	of			
	conduct intended	to produce mental or emotiona	I			
	distress. Every re	esident shall also be free from	Ì			
1	non-therapeutic c	hemical and physical restraints cumented emergencies, or as	·		1	
	except in fully dod	ing after examination by a			Ì	
	resident's physicia	an for a specified and limited				
1	period of time, an	d only when necessary to				
,	protect the reside	nt from self-injury or injury to				
	others.					
1	This BANI Describes	mont is not met as avidenced			İ	
1	I nis MN Requirer	ment is not met as evidenced	1			

	<u>ta Department of He</u> T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		00589	B. WING		C 02/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	ĺ	
	RE RESIDENCE & RI	CILAD OTD	OUIS AVENU	E		
BATSHU			MN 55802	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
21850	Continued From pa	age 10	21850			
	failed ensure one of from maltreatment staff failed to follow related to falls which falls and implement assessment and stactual harm when fall from the wheel Findings include: Record review est with dementia with of a stroke, and h	y and record review, the facility of one residents(R1) was free . R1 was neglected. The facility policies and procedures the included assessing R1 after adequate review, upervision. This resulted in R1 sustained a head injury in a chair, and later died. ablished R1 was diagnosed aggressive behaviors, history ypertension as noted in a lated 10/10/14. R1 had resided ocked unit.				
	to be at a high risk drug use, incontin- awareness. The ir in low position and assessment dated recent falls, was a impulsiveness, po into limitations. R verbalize wants at status note dated sometimes unders and unclear. Review of the prohad ten falls from	ote dated 10/13/14 assessed R1 of falls related to psychotropic ence, and poor safety interventions noted were the bed alarms. The physical therapy if 1/2/14 noted the resident had a high risk for falls due to for safety awareness and insigh 1 was not able to clearly and needs to the staff, the health 10/13/14 noted that R1 was stood and speech was garbled gress notes revealed that R1 7/5/14, until he was discharged 11/24/14. Nine of the falls	t			
	occurred on the e	vening shift and eight of the fall ut of the wheelchair.	s			

Minnesota Department of Health STATE FORM

The "Care Area Assessment" (CAA) dated

	ta Department of He	ealth		CONCERNATION:	(X3) DATE	SURVEY
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER	A. BUILDING: _		_	
					C	
		00589	B. WING		02/2	0/2015
NAME OF S	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		1601 ST L	OUIS AVENU			
BAYSHO	RE RESIDENCE & RI	EUAD CTD	MN 55802			
	CUMMADV ST/	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	1 137 17 66	
21850	Continued From pa	age 11	21850			: I
	1/27/14 noted that	R1 was a high risk of falls and				
	noted the seat helt	and alarms. The assessment				
	noted that R1 shou	uld have "high visible placing	ļ			
	while up in the whe	eelchair for closer monitoring"				
	because of R1 star	nding up suddenly on his own.				
		_]			
	The care plan date	ed 11/22/14 noted that R1 was	1			
	at risk of falls and	had a history of falls at home				
	and at the facility	The care plan noted that staff]			
	should anticipate F	R1's needs and observe for nd ambulation. Other	1 !			1 1
	unsare transiers a	to toilet every 2 hours, put call	1			
	light in reach follow	w the facility fall protocol. The				
	care plan noted that	at staff were to check blood	1			
	sugars if indicated	, observe for seizure activity,				
	and medication sig	de effects. The care plan also				: :
	noted to regularly	give R1 snacks of pudding in				
	the evenings, to as	ssist R1 to stand up and				
	ambulate when R	1 appeared restless, and to				
		naterial on the seat of the	1			!
	wheelchair. The b	ed was to be in low position	1			
	with a moor mat, all	nd an alarm was used in the eelchair. The care plan noted				
	that R1 used a rec	gular wheelchair without				
ı	footrests and wou	ld propel himself short				
	distances. Superv	rision of R1 while up in the	- 			
	wheelchair was no	ot addressed in the care plan.				!
	The Nursing Assis	stant assignment sheet dated	1			
		alarm was to be used in the				
	wheelchair and if	R1 was trying to stand				
	repetitively, to am	bulate with him as tolerated.	1			
		while up in the wheelchair was	1			
	not addressed.					
	The activity calen	dar documenting activities				
ĺ	provided to R1 for	r November 2014 was reviewed	ı, İ			
İ	there were no act	ivities provided to R1 after 4	·			1
ŀ	p.m. R1 would er	ngage in activities offered, the				1
İ	care conference r	note date 11/5/14 noted R1				

would take part in sensory, music, snack, and

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					l c l
		00589	B. WING		02/20/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST		
BAYSHO	RE RESIDENCE & RI		OUIS AVENU	E	
BAISHO			MN 55802	DON SPERIO DI ANI DE CORRECTI	ON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
21850	Continued From pa	age 12	21850		
	reading.				;
	self releasing seat wheelchair as a fall Assessment" dated belt was able to be facility did not have The care conferent that the family had the seatbelt, the rewas not noted. The risks and benefits the restraint assessment has seat belt was to during a trial of notincreased falls, who progress notes refalls on 11/5/14 ou p.m. there was a fall wheelchair in an unthese falls were noted.	d 10/2014 noted that a Velcro belt was worn when in I prevention. The "Device d 5/10/13 for R1 noted that the removed by the resident, the a more recent assessment. I ce note on 11/5/14 reflected agreed to a trial to discontinue the belt ere was no assessment on the of discontinuing the seatbelt on asment dated 11/10/14, the belt scontinued on 11/10/14. The tent dated 11/10/14 noted that used for unsafe mobility and the using the belt there were no nich was not accurate. The flected that R1 had unwitnessed to f bed, and on 11/8/14 at 7:15 all when R1 tipped over the nwitnessed fall in his room.			
	11/17/14, 11/22/14 had a series of 3 if velcro self releasing a trial period, there falls for patterns a interventions to re The "Resident Inc. 4:20 p.m., R1 was room and was four wheelchair with the	and incident reports dated and 11/24/14 documented R1 falls from the wheelchair after an seatbelt was discontinued for e was no assessment of the and root causes to develop educe the risks of falls. Sident Report" dated 11/17/14 at a unobserved in the activity and on his knees next to the lee alarm sounding, which had the care plan dated 10/2014.			

	ta Department of He	ealth	(Y2) MILITIDI E	CONSTRUCTION	(X3) DATE	SURVEY
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-			LETED
AND PLAN	OF CORRECTION		A. BUILDING.			,
		00589	B. WING		1	0/2015
		etheet And	SPESS CITY S	TATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		OUIS AVENU			
BAYSHO	RE RESIDENCE & R	EUAD CTD	MN 55802			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21850	Continued From pa	age 13	21850			
	Fall Huddle Investinot known what Rathe fall occurred. No implemented and to pattern of similar fall was do report dated 11/22 observed R1 "lung wheelchair falling lounge area. It was head, and no injurstanted neurological noted that R1 was side, the physiciar next neurological Fall Huddle Invest 11/22/14 with no restrict of the rest neurological fall Huddle Invest 11/22/14 with no restrict of the restrict of t	gation Worksheet" noted it was I was attempting to do when Io new interventions were the fall was not reviewed for a falls. Documented on a fall incident 1/14 at 3:45 p.m., an aid forward out of the face first on the floor" in a se noted that the resident hit his yeas identified. The nurse forward at 6:45 p.m. In drowsy and leaning to the left of was notified by phone and the check was normal. The "Post igation Worksheet" was dated new interventions added, and a				
	had another fall of the activity room a was found by a nualarm sounded. Refeet from the where R1's head was not c.m. abrasion". A was normal. The and noted on the 11/24/14 that there to put the seatbel recommended chrisk assessments done according to normal limits. The ice applied to the	ort dated 11/24/14 at 5 p.m., R1 at of the wheelchair. R1 was in and had an unwitnessed fall, he ursing assistant (NA) when the 1 was found on his back a few elchair, an injury to the back of sted, " a 3 centimeter (c.m.) by 2 neurological check at that time nurse notified a family member "Post Fall Huddle" dated to was a request from the family to back in use. The nurse anging the care plan and the fall. Neurological checks were of facility policy and were within the resident was given first aid and injury on the back of the head.				

Minnesot	ta Department of He	ealth		CONSTRUCTION	(X3) DATE SURVEY	
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	COMPLETED	
AND PLAN	OF CORRECTION	(DEITH TO MOIS INCIDENCE	a. Building: _ 		l c	
		00500	B. WING		02/20/2015	
		00589				
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
BAVGHO	RE RESIDENCE & RI		OUIS AVENU	Ē		
BAISHU			MN 55802	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
21850	Continued From pa	age 14	21850			
	look right and was R1 was pale, non- extremities, R1 wa	n't himself". The nurse noted responsive, and not moving his is transported to the hospital, to have several subdural				
	noted the falls R1 hemorrhages (blee placed on hospice 11/28/14 and the of	arge summary dated 11/28/14, had resulted in three brain eding), The resident was care. The resident died on death certificate dated 11/29/14 f death was intracerebral				
	2/4/14 at 10:10 a.i NA-E stated R1 di would get restless afternoon. R1 wou the wheelchair, bu be distracted. NA- residents on the n supervision for sa while giving cares	t (NA)(E) was interviewed on m. and was familiar with R1, id the best during the day, but and agitated in the late ald stand and try to walk from ut would enjoy visiting and could E stated that most of the nemory unit need to have fety, and this could be difficult in rooms and it was best to available for supervision of unit.				
	2/9/14 at 11:45 a. frequently restles stand up unexpection wheelchair. She stactivities and kepting activities and kepting activities and kepting activities.	(NA)(G) was interviewed on m. and stated that R1 was s in the evenings. R1 would ctedly and quickly while in the stated R1 did better if involved in the busy, but there had been a ity staff in the evenings on R1's				
	interviewed on 2/	stered nurse (RN)(J) was 10/15 at 11:10 a.m. and verified RN covered other units on the the memory care unit, and a	i			

Minnesota Department of Health			L (VO) MULTIPLE	(X3) DATE	(3) DATE SURVEY			
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ·	E CONSTRUCTION	COMF	COMPLETED		
AND PLAN	OF CORRECTION	IDENTIA IOMANIA NOMBELIA	A. BUILDING:					
			0.144110			02/20/2015		
		00589	B. WING			EU/2013		
NAME OF S	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE				
		1601 ST	LOUIS AVEN	UE				
BAYSHO	RE RESIDENCE & R	PUAD CTD	MN 55802					
	5. H. H. A. S. A.	ATEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF	ORRECTION	(X5)		
(X4) ID PREFIX	/EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ON SHOULD BE	COMPLETE DATE		
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	DEFICIENC	٧)			
			 					
21850	Continued From page	age 15	21850			1		
	nurse was not on t	he unit at all times. The unit						
	was staffed with 2	nursing assistants which relied	l 					
	on the nursing ass	istant assignment sheet to				!		
	direct cares with re	esidents. RN-J stated that R1						
	was frequently agi	tated on the evening shift and						
	did better if he was	s occupied, would hold a						
	baseball and would	d settle. RN-J was not aware o	'					
	activities occurring	on the memory care unit on RN-J had discussed with the						
	the evening shirt.	to keep R1 in sight when up in	, 1					
	the wheelchair bea	cause of suddenly standing and	4					
	trying to walk.	3						
	'					İ		
	The nurse manage	er (RN-B) was interviewed on				·		
	2/4/15 at 10:50 a.i	m, and verified that there had						
	been concern abo	out the seatbelt in use for R1	.			Ì		
	because he was r	not able to release it on his own	'					
	and it would be a	restraint. R1 had tipped over in h the belt in place. RN-B was						
	nis wheelchair wit	substitute interventions						
	implemented at the	at time to reduce the risk of R1	ı					
	suddenly standing	and having a fall. RN-B could						
	not verify when th	e trial occurred for not using th	e i					
	seatbelt and if the	ere was an assessment of the	ľ			1		
	risks and benefits	of using the belt. RN-B noted	1					
	the process to rev	view falls at morning stand up	ļ					
	and at an interdis	ciplinary meeting should occur				ļ		
	but was not able to	to verify that there had been						
	discussion of the	falls for R1, or an overall e interventions and whether the	ev			Ì		
	were effective to	reduce the risk of falls.	-,					
	Mele ellective to	request the time of terror						
	The facility policy	for falls titled "Falls- Clinical						
1	Protocol" dated 4	/13 was reviewed. The policy						
	noted that a resid	lent should be assessed for fall						
	risk on admission	and document risk factors. The	ne					
[policy directs stat	ff to evaluate falls to identify	.			Ì		
	causes of fails. T	he policy noted that staff should	u					
	evaluate the timil	ng of falls, identify patterns, and	1					
1	any underlying m	nedical cause of falls. It is noted						

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE	(X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, .		COMP	COMPLETED				
	00589				02/2	0/2015				
	DOMESTIC OF CHIRD IS CO.		DRESS, CITY, S	STATE, ZIP CODE						
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE									
BAYSHO	RE RESIDENCE & RI		MN 55802							
(X4) ID PREFIX TAG	/EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE						
21850	Continued From pa	nge 16	21850							
2.000	that if a resident co cannot be identified the situation with the medical director.	ontinued to fall and a cause d the nursing staff will discuss ne attending physician and								
	interviewed on 2/1: the system in place had been identified agency had been if She was not able to was started for R1 completed at that was discontinued assessment of the been done at that there was not a co the falls for R1 to interventions, ther pull the informatio verified there had wheelchair for saf- activities or super- for falls, or a medi- contributing to fall interdisciplinary te	or of nursing (DON) was 2/15 at 1 p.m. and verified that at the facility to prevent falls as an issue, and a consulting in place to improve the system. To identify when the seatbelt or if an assessment had been time. She verified that the belt on 11/10/14, and an a risks and benefits had not time. The DON verified that the perfective assessment of identify patterns and effective was not a review of falls to intogether and evaluate. She not been an assessment of the ety, an increase in diversional vision, a pharmacy evaluation ical condition identified as s. The DON stated that the sam (IDT) had not been actively solving issues with falls.								
	interviewed on 2/4 interventions that noted that falls wa training planned f be updated. A ma the IDT review fal review each fall a SUGGESTED MI The Director of N	n management consultant was 4/15 at 12 p.m. and outlined the were planned for the facility an as a main concern. There was or 2/5/14 and the policy was to jor emphasis would be to have its and create assessments that and the root cause analysis. ETHOD OF CORRECTION: ursing or designee could and/or revise policies and	e d							

			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	(Martin to the control of the contro	A BUILDING: _		c		
		00589	B. WNG		02/20/	2015	
NAME OF S	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE			
		1601 ST L	OUIS AVENUI			Į	
BAYSHO	RE RESIDENCE & RI		MN 55802	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE	
21850	Continued From pa procedures to ensu- are upheld and res maltreatment. The designee could ed- the policies and pro- Nursing or designer systems to ensure		21850	DETICION			

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245227	(Y2) Multiple Construction A. Building B. Wing	A. Building	
Name of Facility		Street Address, City, State, Zip Code	
BAYSHORE RESIDENCE & REHA	B 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		(5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y6)	Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0323	03/26/2015	ID Prefix		-	ID Prefix			
-	483.25(h)		Reg. #			Reg. #			_
LSC		_	LSC			, LSC			
									_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #		_	Reg. #			
					-				 -
					•				
		Correction			Correction				Correction
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LSC			LSC		•	LSC			_
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		Correction			Correction				Correction
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Reg. #		_	Reg. #		-	Reg. #			
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		Correction			Correction				Correction
		Completed			Completed				Completed
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LSC			LSC		· :_	LSC			
Barrian and D			D -4					<u> </u>	
Reviewed By		•	Date: 04/16/2015	Signature of Surve	-	າວ		Date:	04/2015
State Agency	,	·····	04/16/2015	<u> </u>	1969	·			06/2015
Reviewed By	Reviews	d By	Date:	Signature of Surve	yor:			Date:	
CMS RO		·-·			<u> </u>				
Followup to	Survey Completed on:					eficiencies. Was			
	2/20/2015			Uncorrecte	d Deficiencies	(CMS-2567) Sent t	to the Facility?	YES	NO
Form CMS - :	2567B (9-92)			Page 1 of 1			Event ID:	P89512	

State Form: Revisit Report							
(Y1)	Provider / Supplier / CLIA / Identification Number 00589	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/6/2015			
Name of Facility BAYSHORE RESIDENCE & REHAB CTR			Street Address, City, State, Zip Code 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	r	/5) C	Date
ID Prefix	20830	Correction Completed 03/26/2015	ID Prefix	21850	Correction Completed 03/26/2015	ID Prefix			Correction Completed
Reg. # LSC	MN Rule 4658.0520 Subp.	1 -	Reg. # LSC	MN St. Statute 144.651 Sul	bd. 1	Reg. # LSC			- -
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		_	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		•	Date: 04/16/20	Signature of Surve	yor: 196	92	·	Date:	06/2015
Reviewed By CMS RO			Date:	Signature of Surve	•	<u> </u>		Date:	0,2013
	Survey Completed on: 2/20/2015 A: REVISIT REPORT (6)	5/99)		_		Deficiencies. Was s (CMS-2567) Sent t	to the Facility?	YE\$	NO