MINNESOTA MDH DEPARTMENT OF HEALTH

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#: H5227053

Date: January 19, 2016

Date of Visit: October 12, 2015
Time of Visit: 8:15 a.m. – 4:30 p.m.

By: Barbara White, RN, Special Investigator

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

☐ Facility Self Report ☒ Complaint

Allegation(s): It is alleged that a resident was neglected when s/he did not receive nine doses of medication, and was hospitalized.

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 Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ 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 the preponderance of the evidence neglect did occur when the resident did not receive anti-seizure medications as ordered. The resident had an increase in seizures, confusion, and falls; and was hospitalized.

The resident's medical record was reviewed. The resident had diagnoses including seizures and a history of a head injury, s/he had resided at the facility for over a year. The resident had several medications for a complex seizure disorder according to the signed physician's orders.

The resident was sent to the emergency room (ER) for increased seizure activity, garbled speech, and jerking movements. The ER physician's orders increased zonisamide (Zonegran) from 200 mg twice a day to 300 mg twice a day, and directed to continue all other medications as before. The medication administration record indicated the dose of 300 mg was given once, but the order was not transcribed correctly to continue the dose. The resident was given 200 mg by error for several days until s/he was hospitalized for increased seizures.

Another seizure medication, lacosamide (Vimpat) was discontinued by error at that time, and the resident missed nine doses until the error was corrected.

Documentation and staff interviews indicated the resident had increased confusion and a fall on the night shift, was sent to the ER for increased seizures, and another day was noted to be confused with garbled speech and was hospitalized for 9 days. The facility had not identified the error. The error happened due to the nurse discontinuing lacosamide (Vimpat) inadvertently on the computer record when the resident returned from the ER, and that the increased dose of zonisamide (Zonegran) was entered into the computer.

The Neurologist caring for the resident was interviewed and verified that not receiving both the anti-seizure medications at the correct doses increased risk for seizure activity. S/he further stated that the confusion and garbled speech noted by the nursing staff could have been unrecognized seizures.

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 did not have a system in place to monitor transcriptions for accuracy and to prevent errors.

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 for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) 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 Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):
Additional training for all nurses and auditing had been implemented by the facility. The facility had a revisit conducted and the issues had been corrected.

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	☐ 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
☒ Nurses Notes	☐ Meal Intake Records
☐ Activities Reports	☐ Weight Records

☐ Therapy and/or Ancillary Services Records ☒ Assessments

☐ Skin Assessments ☒ Care Plan Records

☐ Service Plan ☐ Other, specify: _____

Other pertinent medical records:

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

☐ Police Report ☐ Other, specify: _____

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: _____

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

◉ Yes ○ No ○ N/A Specify: _____

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: _____

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 8

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 7

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant 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 Specify: _____

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

Were photographs taken: ○ Yes ◉ No Specify: _____

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	C 10/23/2015

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 case #H5227053. As a result, the following deficiencies are issued.	F 000	The Plan of Correction constitutes Bayshore Residence and Rehabilitation Center's written compliance for the deficiencies cited. However, the submission of this Plan of correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law.	
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225	1. Resident #1 with a diagnosis of TBI and seizure disorder has remained stable to his level of function. - Resident # 2 has shown no ill effects related to the missed doses of medication and has remained stable. - Resident # 3 with a diagnosis of atrial fibrillation has remained stable with no ill effects 2. All residents would be considered at risk. 3. Facility staff will be in serviced on the Vulnerable Adult policy and procedure and the requirement to notify the Administrator immediately and to report the alleged	

Don Babbitt Administrator 12-17-2015

abuse/neglect/mistreatme nt promptly to the state agency.
The Director of Nursing was re-educated on 10/2602015 by the Administrator on timeliness of reporting to OHFC.
Completion date of 11-18-2015.
The Administrator/designee will be responsible/.

4. The vulnerable adult reports will be reviewed and monitored at the Monthly QA meeting for six (6) months

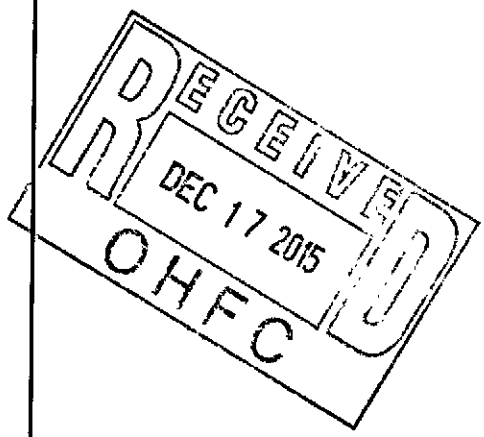
SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and



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

Don Babbitt Administrator 12-17 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 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to immediately report to the administrator and the state agency (SA) alleged violations of neglect for 2 of 2 (R1 and R2) residents reviewed for significant medication errors that needed medical care. Findings include: R1 had a significant medication error that was noted by the facility on 9/23/2015, the incident report noted the error was reported to the Director of Nursing (DON) on 9/23/2015, but was not reported to the state agency (SA) until 9/25/2015. R1's medical record was reviewed. R1 had diagnoses including seizures and head injury, he had resided at the facility for over a year. Review of the medication error report dated 9/23/2015 indicated R1 did not have a seizure medication lacosamide (Vimpat) restarted after an emergency room visit, and missed a total of 9 doses of the medication over 5 days. The DON had been notified on 9/23/2015 at 12 p.m., there was no record of the administrator being notified. The incident was not reported to the SA until 9/25/2015. Progress notes indicated that R1 had several seizures, falls and a change in mental status, and	F 225		

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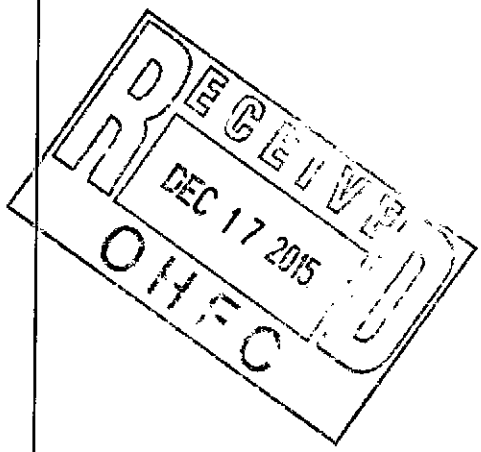
F 225	Continued From page 2 needed to be seen in the emergency room (ER) on 9/20/2015 and hospitalized on 9/23/2015. R2's medical record was reviewed. R2 had diagnoses including primary thrombophilia (blood clots) and a history of pulmonary embolism (blood clot in the lungs). The medication error incident report dated 10/3/2015 indicated R2 did not have warfarin (an anticoagulant medication) restarted at the time he returned to the facility from the hospital for treatment of pneumonia from 9/30/15 until 10/3/15, missing a total of 3 doses. R2 was sent to the ER on 10/3/15 to evaluate the effects of missing the medications after an INR protime lab report was too low. The error was discovered on 10/3/2015, and reported to the DON on 10/3/2015 at 3 p.m., the report to the SA was not done until 10/6/2015. There was no record of notification of the administrator. The DON said in an interview at 1:15 p.m. on 10/12/2015 that medication errors were reportable if they were serious and required medical care, and there was no reason given for not reporting immediately to the SA. The facility's "Abuse Prevention Plan" (undated) indicated that the DON was the designated administrator when the administrator was absent from the building, and the facility professional that received the report of maltreatment was responsible for immediately notifying the administrator, and the state agency. The policy indicated that neglect included the failure to provide services necessary to maintain physical health.	F 225		

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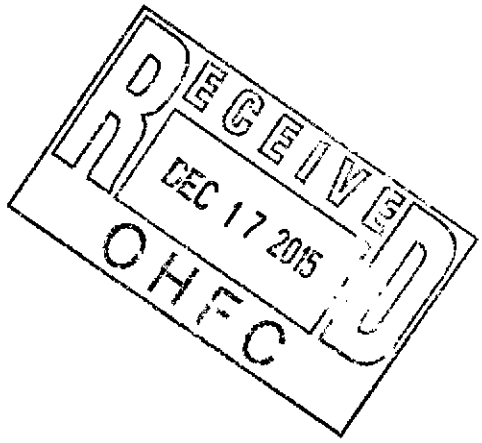
F 226	483.13(c) DEVELOP/IMPLMENT	F 226	1. Resident # 1 with a diagnosis of TBI and seizure disorder has remained stable to his level of function. Resident # 2 has shown no ill effects related to missed doses of medication and has been stable. Resident # 3 with a diagnosis of atrial fibrillation has remained stable with no ill effects 2. All residents would be considered at risk related to the alleged deficiency. 3. Facility staff will be inserviced on the vulnerable adult prevention policy to ensure that all allegations of resident neglect are reported promptly to the Administrator and to the state agency. The Director of Nursing was re-educated on the vulnerable adult prevention policy and reporting of any alleged neglect will be reported promptly to	

			the Administrator and to the state agency. 4. The Vulnerable adult reports will be monitored in the monthly QA meeting for six (6) months. The Administrator will be responsible. Completion date of 11-18-2015
SS=D	ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to implement their vulnerable adult prevention policy to ensure all allegations of resident neglect were immediately reported to the administrator and to the required state agency for 2 of 2 (R1 and R2)) resident reviewed for significant medication errors. Findings include: Review of the facility's policy and procedure titled 'Abuse Prevention Plan' (undated) revealed neglect was defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The policy states any person who had reasonable cause to suspect that a resident had been neglected, must report the neglect immediately to the administrator. The administrator, director of nursing, or designee would immediately report the suspected maltreament to the state agency (SA). R1 had a significant medication error that was noted by the facility on 9/23/2015, the incident report noted the error was reported to the Director of Nursing (DON) on 9/23/2015, but was not reported to the state agency (SA) until 9/25/2015.		



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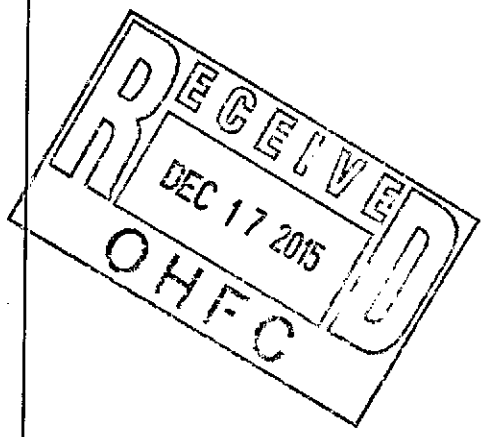
F 226	Continued From page 4 R1's medical record was reviewed. R1 had diagnoses including seizures and head injury, he had resided at the facility for over a year. Review of the medication error report dated 9/23/2015 indicated R1 did not have a seizure medication lacosamide (Vimpat) restarted after an emergency room visit, and missed a total of 9 doses of the medication over 5 days. The DON had been notified on 9/23/2015 at 12 p.m., there was no record of the administrator being notified. The incident was not reported to the SA until 9/25/2015. Progress notes indicated that R1 had several seizures, falls and a change in mental status, and needed to be seen in the emergency room (ER) on 9/20/2015 and hospitalized on 9/23/2015. R2's medical record was reviewed. R2 had diagnoses including primary thrombophilia (blood clots) and a history of pulmonary embolism (blood clot in the lungs). The medication error incident report dated 10/3/2015 indicated R2 did not have warfarin (an anticoagulant medication) restarted at the time he returned to the facility from the hospital for treatment of pneumonia from 9/30/15 until 10/3/15, missing a total of 3 doses. R2 was sent to the ER on 10/3/15 to evaluate the effects of missing the medications after an INR protime lab report was too low. The error was discovered on 10/3/2015, and reported to the DON on 10/3/2015 at 3 p.m., the report to the SA was not done until 10/6/2015. There was no record of notification of the administrator.	F 226		

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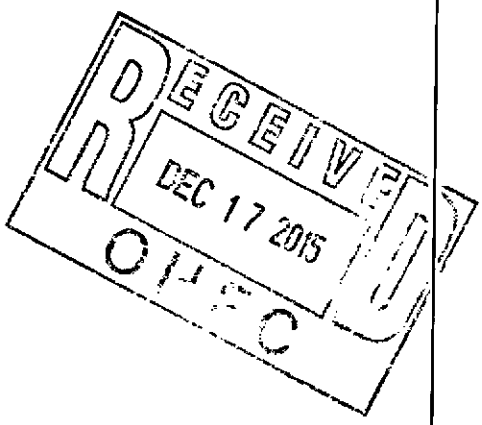
F 226	Continued From page 5 The DON said in an interview at 1:15 p.m. on 10/12/2015 that medication errors were reportable if they were serious and required medical care, and there was no reason given for not reporting immediately to the SA.	F 226		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333	1. Resident #1 with a diagnosis of TBI and seizure disorder has remained stable to his level of function. Resident # 2 has shown no ill effects related to missed doses of medication and has been stable. Resident # 3 with a diagnosi of atrial fibrillation has remained stable with no ill effects. All medication records and physician orders for residents receiving Coumadin were audited and confirmed as accurate. 2. License staff and TMAs will be inserviced on medication administration. The License staff will be inserviced on transcribing orders.	

The License staff will re-educated on the electronic transcription procedure specific to Coumadin orders. Education and inservice will be completed by 11-18-2015
The DON/Designee will be responsible.

3. A daily audit will be implemented to assure that INRs are scheduled and drawn as ordered; Coumadin clinic and/or physician has been notified of the results and Coumadin orders are transcribed/entered and faxed to the pharmacy per policy. The Nurse managers are responsible for the daily logs of the above.
Implemented by 11-18-2015
The Director of Nursing/designee will be responsible.

4. The daily audits will be presented to the monthly QA meeting to monitor the effectiveness and determine further education needs.

The DON/designee will be responsible.



any significant medication errors.

This REQUIREMENT is not met as evidenced

	by: Based on observation, interview, and record review the facility failed to ensure 3 of 4 residents (R1, R2, R3) were free from significant medication errors. This caused actual harm to R1 and R2 who required hospitalization aggressive medical treatment required to correct the results of the omission. Findings include: R1's medical record was reviewed. R1 had diagnoses including seizures and a history of a head injury, he had resided at the facility for over a year. R1 had several medications for seizure disorder according to the signed physician's orders. The medication administration record (MAR) for September 2015 indicated: Lacosamide (Vimpat) 100 mg twice a day (bid), lamotrogine (Lamictal) 500 mg bid, zonisamide (Zonegran) 200 mg bid, lorazepam (Ativan) three times a day, and as needed for anxiety and agitation related to seizures. The progress notes indicated that R1 had been				

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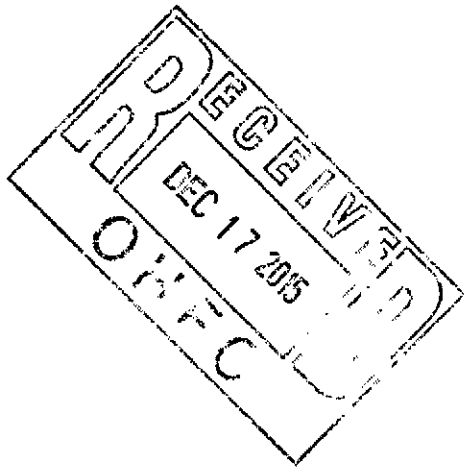
F 333	Continued From page 6 hospitalized from 8/14/2015 to 8/18/2015. The hospital discharge summary dated 8/18/2015 indicated R1 had been treated for a seizure disorder with poor recent control, and toxicity of an anti-epileptic drug phenytoin (Dilantin), this medication was gradually reduced. Another anti-epileptic medication zonegran (Zonesamide) was added. The discharge summary noted that R1 had breakthrough seizures and ongoing problems with generic phenytoin causing variable bioavailability (level of the medication in the bloodstream). The neurologist progress note dated 8/15/15 indicated "Looking over the last several DPH (Dilantin) levels there has been no correlation between dose and levels, I wonder if this is being administered accurately." The nurse progress note dated 9/18/2015 indicated R1 was sent to the emergency room (ER) on 9/18/2015 for increased seizure activity, garbled speech, and jerking movements. The nursing progress note dated 9/18/2015 indicated R1 returned from an emergency room (ER) visit 9/18/2015 with new orders for seizure medication. The Emergency Department summary dated 9/18/2015 indicated R1 had been evaluated for increased seizures, the physician's orders and written prescription increased an anti-epileptic medication zonisamide (Zonegran) from 200 mg twice a day to 300 mg twice a day. The summary directed to continue all other medications as before. The MAR for September 2015 documented lacosamide (Vimpat) was discontinued at 4:40 pm on 9/18/2015, and was restarted on 9/23/2015 at 6:30 a.m. There was no record of lacosamide (Vimpat) administered on 9/18/2015	F 333		

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	245227	A. BUILDING _____ B. WING _____	C 10/23/2015

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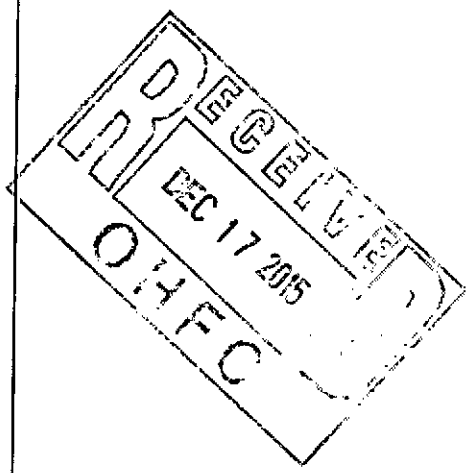
F 333	Continued From page 7 at bedtime, until it was given in the morning on 9/23/15, missing a total of 9 doses over 5 days. The MAR for September 2015 documented 300 mg of zonisamide (Zonegran) given on the evening dose on 9/18/2015, the order for 200 mg twice a day (bid) was not updated, and the MAR indicated R1 received 200 mg total twice a day on 9/19/2015 and 9/20/2015, instead of the 300 mg bid ordered 9/18/2015. R1 was sent to the ER on 9/20/2015 for increased seizure activity, the ER record noted the recent change from 200 mg bid to 300 mg bid on 9/18/2015. The discharge summary from the ER dated 9/20/2015 indicated "after discussion with your neurologist, you should stay on the same dose of zonisamide". The physician (neurologist) caring for R1 was interviewed on 10/23/2015 at 12:30 p.m. and verified that R1 should have stayed on 300 mg bid of zonisamide. The September 2015 MAR noted zonisamide (Zonegran) 200 mg. bid administered remained from 9/20/2015 until R1 was hospitalized on 9/23/2015. The facility medication error report dated 9/23/2015 indicated R1 had lacosamide (Vimpat) discontinued without an order from the physician from 9/18/2015 to 9/23/2015. The lacosamide (Vimpat) 100 mg bid had been discontinued by error by the nurse when processing orders on return from the hospital ER, and not given until 9/23/2015. The nursing progress notes documented: on 9/19/2015, R1 had increased confusion and a fall on the night shift. On 9/20/2015 R1 was observed	F 333		

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F 333	Continued From page 8 to have 2 seizures, was sent to the ER and returned to the facility. On 9/22/2015 R1 had a seizure, and in the morning of 9/23/2015 was noted to be confused with garbled speech and was hospitalized for 9 days. The hospital admission history and physical dated 9/23/2015 indicated that R1 was acutely confused, and the physician noted "Unsure if mental status is due to change in medications", R1 was treated for dehydration, and had medication levels monitored. The neurologist noted on 10/1/2015 R1 was at his neurological baseline. R1 returned to the facility on 10/2/2015. The nurses progress notes dated 10/6/2015 indicated R1 was assessed to have lung congestion and was seen in the ER, diagnosed with aspiration pneumonia, and returned to the facility Another ER visit occurred on 10/7/2015, the emergency department orders dated 10/7/2015 indicated R1 was assessed for disorientation , there were no changes made to medication orders. The nurse manager RN-C was interviewed on 10/21/2015 at 2:30 p.m., and verified that R1 did not receive zonisamide (Zonegran) 300 mg bid from 9/19/2015 to 9/23/2015 as ordered. The nurse manager stated that R1 usually had a couple seizures a month as a baseline, but his seizure activity increased in August 2015 when his seizure medicines were changed. RN- D was interviewed at 2 p.m. on 10/12/2015 and stated the Lacosamide (Vimpat) was discontinued by error when the orders were being processed on 9/18/15 when R1 returned from the ER. RN-D stated that the increase of dosage for	F 333		

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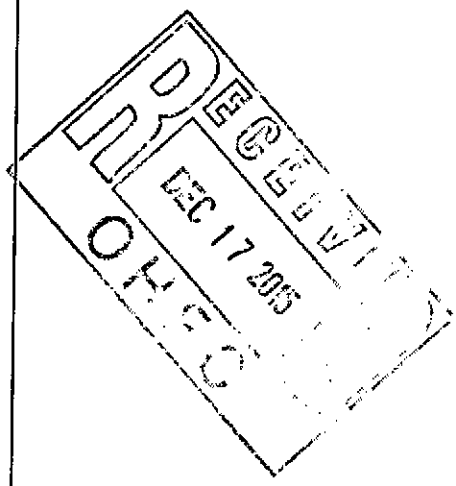
F 333	Continued From page 9 another seizure medication zonisamide (Zonegran) was put into the computer and the additional 100 mg was given on 9/18/2015. The physician (neurologist) caring for R1 was interviewed on 10/23/2015 at 12:30 p.m. and verified that R1 not receiving both the anti-epileptic medications at the correct doses was an increased risk for seizure activity. He further stated that the confusion and garbled speech noted by the nursing staff could have been unrecognized seizures. The Director of Nursing (DON) was interviewed at 8:20 a.m. on 10/12/2015 and stated the error happened due to the nurse discontinuing the medication lacosamide (Vimpat) inadvertently on the computer record when the resident returned from the ER on 9/18/2105, and that retraining had been done with the nurses. R2 medical record was reviewed. R2 had diagnoses including primary thrombophilia (blood clots) and a history of pulmonary embolism (blood clot in the lungs). Since admission to the facility R2 had received warfarin (Coumadin) at a dose of 2.5- 5 mg on a daily basis with regular monitoring of the protime INR. Warfarin (Coumadin) is an anticoagulant medication given to prevent blood clots, and the blood is periodically monitored for clotting time with a laboratory test of the protime international normalized ratio (INR) to determine the correct dosage. Hospital discharge orders dated 9/29/2015 indicated R2 had been treated for pneumonia. The hospital discharge papers and orders dated	F 333		

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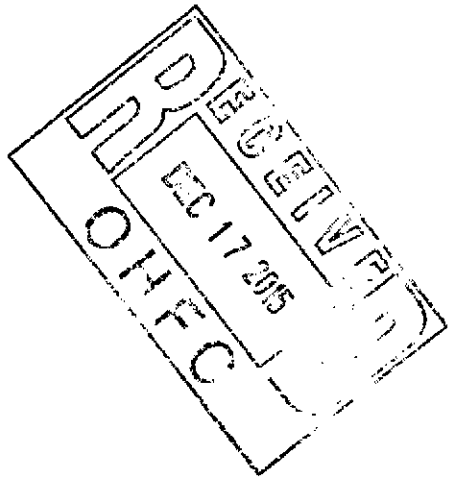
F 333	Continued From page 10 9/29/2015 indicated that R2 had received warfarin (Coumadin) on 9/29/15 and had an order for warfarin 5 mg tablet on 9/30/2015, and to recheck the INR on 10/1/2015, the goal INR of 2.0-3.0 was noted by the doctor. The September and October 2015 MAR did not have a record of warfarin administered on 9/30/2015, 10/1/2015, 10/2/2015, and 10/3/2015. The nursing progress note dated 10/3/2015 documented that R1 was sent to the ER on 10/3/2015 at 6 p.m. due to a clotting protime international normalized ratio (INR) of 1.2 and complaints of leg pain. The nurse progress note dated 10/4/2015 at 1 a.m. indicated R2 returned to the facility after receiving additional injectable anticoagulant medications and diagnostic procedures to determine there was no blood clot. The medication error report dated 10/3/2015 documented that R2 returned from the hospital 9/29/2015, R2 did not have Coumadin orders and no one followed up. R2 had an INR checked, it was called to the medical doctor and the doctor ordered R2 to be evaluated at the ER. R2 was interviewed at 2:30 p.m. on 10/12/15 and stated he knew that his medications were not given correctly. He said things got straightened out but that he was still worried and checked the pills he was given. A large bruise on his left lower abdomen was observed, and he said it was from the injectable anticoagulant medications. The primary physician for R2 was interviewed on 10/21/15 at 9:45 a.m. and stated that she had been called when the facility noted the error on	F 333		

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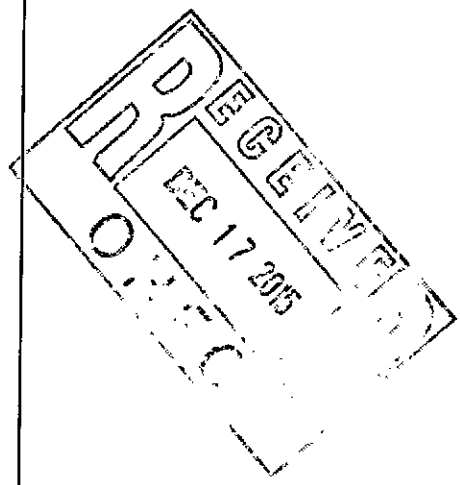
F 333	Continued From page 11 10/3/2015 and R2 had not received wafarin since 9/29/2015. An immediate INR protime was completed, the protime was 1.2, which was a risk for R2 because of his history of clots. She stated that R2 was sent to the ER and needed to have Coumadin and an injectable anticoagulant enoxaparin (Lovenox) was given. The additional Lovenox was administered for 10 doses. R2's physician stated that this omission of Coumadin put R2 at a higher risk for developing additional clots, and it was physically uncomfortable for R2 to have additional injectable medication. The nurse manager RN-C stated in an interview at 2:30 p.m. on 10/12/2015 that the orders for wafarin were not entered into the computer correctly for transcription. She stated that some of the orders were misplaced by the health unit coordinator's desk and were not entered timely. She acknowledged that this was not the expected process and that the nurse was re-educated. R3 medical record was reviewed, the September 2015 MAR indicated R3 had diagnoses including atrial fibrillation (a conduction problem of the heart) and a history of blood clots in the legs. R3 had warfarin (Coumadin) an anticoagulant medication ordered daily to prevent blood clots. The September MAR for R3 had an order dated 8/28/2015 of warfarin 4 mg until 9/4/2015, and to have an INR done on 9/4/2015. September 2015 MAR did not have documentation of warfarin (Coumadin) given 9/4/15, 9/5/15, and 9/6/15. The nurse progress note dated 9/7/2015 documented R3 "did not have INR checked on 9/4/15 per order, R3 did not receive Coumadin on 9/4/15, 9/5/15, or 9/6/15". The nurse notified the	F 333		

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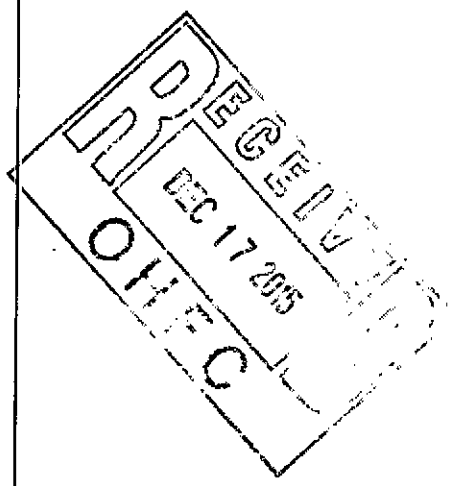
F 333	Continued From page 12 physician, the INR value was checked and wafarin was ordered by the physician. A nurse progress note dated 9/8/2015 indicated there was no adverse effects from the medication error on 9/4/15. The facility policy titled "Adverse Consequences and Medication Errors" dated 2001, noted that a medication error would include an omission for a drug that is ordered but not administered, and the wrong dose given. The orientation and training for nurses included transcription of medication orders on the computer system, and that orders needed to be double checked for accuracy. The DON stated in an interview at 1:15 p.m. on 10/12/2015 that the facility identified errors with transcription of orders on return from the hospital, INR tests being completed, and orders obtained. She stated she had the assistant director of nursing (ADON) send an e-mail to all nurses that included training to double check all orders, and that additional training would be done at the October 2015 nurse's meeting. She stated audits were being done by nurse managers on all resident's on return from the ER or hospital to assure the orders were correct.	F 333		

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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 # H5227053. As a result, the following correction orders are issued.	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	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.	
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or	21545		

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21545	Continued From page 2 (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 3 of 4 residents (R1, R2, R3) were free from significant medication errors. This caused actual harm to R1 and R2 when they were hospitalized and required	21545		

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21545	Continued From page 3 aggressive medical treatment required to correct the results of the omission. Findings include: R1's medical record was reviewed. R1 had diagnoses including seizures and a history of a head injury, he had resided at the facility for over a year. R1 had several medications for seizure disorder according to the signed physician's orders. The medication administration record (MAR) for September 2015 indicated: Lacosamide (Vimpat) 100 mg twice a day (bid), lamotrogine (Lamictal) 500 mg bid, zonisamide (Zonegran) 200 mg bid, lorazepam (Ativan) three times a day, and as needed for anxiety and agitation related to seizures. The progress notes indicated that R1 had been hospitalized from 8/14/2015 to 8/18/2015. The hospital discharge summary dated 8/18/2015 indicated R1 had been treated for a seizure disorder with poor recent control, and toxicity of an anti-epileptic drug phenytoin(Dilantin), this medication was gradually reduced. Another anti-epileptic medication zonegran (Zonesamide) was added. The discharge summary noted that R1 had breakthrough seizures and ongoing problems with generic phenytoin causing variable bioavailability (level of the medication in the bloodstream). The neurologist progress note dated 8/15/15 indicated "Looking over the last several DPH (Dilantin) levels there has been no correlation between dose and levels, I wonder if this is being administered accurately." The nurse progress note dated 9/18/2015 indicated R1 was sent to the emergency room (ER) on 9/18/2015 for increased seizure activity, garbled speech, and jerking movements.	21545		

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21545	Continued From page 4 The nursing progress note dated 9/18/2015 indicated R1 returned from an emergency room (ER) visit 9/18/2015 with new orders for seizure medication. The Emergency Department summary dated 9/18/2015 indicated R1 had been evaluated for increased seizures, the physician's orders and written prescription increased an anti-epileptic medication zonisamide (Zonegran) from 200 mg twice a day to 300 mg twice a day. The summary directed to continue all other medications as before. The MAR for September 2015 documented lacosamide (Vimpat) was discontinued at 4:40 pm on 9/18/2015, and was restarted on 9/23/2015 at 6:30 a.m. There was no record of lacosamide (Vimpat) administered on 9/18/2015 at bedtime, until it was given in the morning on 9/23/15, missing a total of 9 doses over 5 days. The MAR for September 2015 documented 300 mg of zonisamide (Zonegran) given on the evening dose on 9/18/2015, the order for 200 mg twice a day (bid) was not updated, and the MAR indicated R1 received 200 mg total twice a day on 9/19/2015 and 9/20/2015, instead of the 300 mg bid ordered 9/18/2015. R1 was sent to the ER on 9/20/2015 for increased seizure activity, the ER record noted the recent change from 200 mg bid to 300 mg bid on 9/18/2015. The discharge summary from the ER dated 9/20/2015 indicated "after discussion with your neurologist, you should stay on the same dose of zonisamide". The physician (neurologist) caring for R1 was interviewed on 10/23/2015 at 12:30 p.m. and verified that R1 should have stayed on 300 mg bid of zonisamide.	21545		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 5 The September 2015 MAR noted zonisamide (Zonegran) 200 mg. bid administered remained from 9/20/2015 until R1 was hospitalized on 9/23/2015. The facility medication error report dated 9/23/2015 indicated R1 had lacosamide (Vimpat) discontinued without an order from the physician from 9/18/2015 to 9/23/2015. The lacosamide (Vimpat) 100 mg bid had been discontinued by error by the nurse when processing orders on return from the hospital ER, and not given until 9/23/2015. The nursing progress notes documented: on 9/19/2015, R1 had increased confusion and a fall on the night shift. On 9/20/2015 R1 was observed to have 2 seizures, was sent to the ER and returned to the facility. On 9/22/2015 R1 had a seizure, and in the morning of 9/23/2015 was noted to be confused with garbled speech and was hospitalized for 9 days. The hospital admission history and physical dated 9/23/2015 indicated that R1 was acutely confused, and the physician noted "Unsure if mental status is due to change in medications", R1 was treated for dehydration, and had medication levels monitored. The neurologist noted on 10/1/2015 R1 was at his neurological baseline. R1 returned to the facility on 10/2/2015. The nurses progress notes dated 10/6/2015 indicated R1 was assessed to have lung congestion and was seen in the ER, diagnosed with aspiration pneumonia, and returned to the facility Another ER visit occurred on 10/7/2015, the emergency department orders dated 10/7/2015 indicated R1 was assessed for disorientation , there were no changes made to	21545		

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	00589	A. BUILDING: _____ B. WING _____	C 10/23/2015

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21545	Continued From page 6 medication orders. The nurse manager RN-C was interviewed on 10/21/2015 at 2:30 p.m., and verified that R1 did not receive zonisamide (Zonegran) 300 mg bid from 9/19/2015 to 9/23/2015 as ordered. The nurse manager stated that R1 usually had a couple seizures a month as a baseline, but his seizure activity increased in August 2015 when his seizure medicines were changed. RN- D was interviewed at 2 p.m. on 10/12/2015 and stated the Lacosamide (Vimpat) was discontinued by error when the orders were being processed on 9/18/15 when R1 returned from the ER. RN-D stated that the increase of dosage for another seizure medication zonisamide (Zonegran) was put into the computer and the additional 100 mg was given on 9/18/2015. The physician (neurologist) caring for R1 was interviewed on 10/23/2015 at 12:30 p.m. and verified that R1 not receiving both the anti-epileptic medications at the correct doses was an increased risk for seizure activity. He further stated that the confusion and garbled speech noted by the nursing staff could have been unrecognized seizures. The Director of Nursing (DON) was interviewed at 8:20 a.m. on 10/12/2015 and stated the error happened due to the nurse discontinuing the medication lacosamide (Vimpat) inadvertently on the computer record when the resident returned from the ER on 9/18/2105, and that retraining had been done with the nurses. R2 medical record was reviewed. R2 had diagnoses including primary thrombophilia (blood clots) and a history of pulmonary embolism (blood	21545		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21545	Continued From page 7 clot in the lungs). Since admission to the facility R2 had received warfarin (Coumadin) at a dose of 2.5- 5 mg on a daily basis with regular monitoring of the protime INR. Warfarin (Coumadin) is an anticoagulant medication given to prevent blood clots, and the blood is periodically monitored for clotting time with a laboratory test of the protime international normalized ratio (INR) to determine the correct dosage. Hospital discharge orders dated 9/29/2015 indicated R2 had been treated for pneumonia. The hospital discharge papers and orders dated 9/29/2015 indicated that R2 had received warfarin (Coumadin) on 9/29/15 and had an order for warfarin 5 mg tablet on 9/30/2015, and to recheck the INR on 10/1/2015, the goal INR of 2.0-3.0 was noted by the doctor. The September and October 2015 MAR did not have a record of warfarin administered on 9/30/2015, 10/1/2015, 10/2/2015, and 10/3/2015. The nursing progress note dated 10/3/2015 documented that R1 was sent to the ER on 10/3/2015 at 6 p.m. due to a clotting protime international normalized ratio (INR) of 1.2 and complaints of leg pain. The nurse progress note dated 10/4/2015 at 1 a.m. indicated R2 returned to the facility after receiving additional injectable anticoagulant medications and diagnostic procedures to determine there was no blood clot. The medication error report dated 10/3/2015 documented that R2 returned from the hospital 9/29/2015, R2 did not have Coumadin orders and no one followed up. R2 had an INR checked, it was called to the medical doctor and the doctor ordered for R2 to be evaluated at the ER.	21545		

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21545	Continued From page 8 R2 was interviewed at 2:30 p.m. on 10/12/15 and stated he knew that his medications were not given correctly. He said things got straightened out but that he was still worried and checked the pills he was given. A large bruise on his left lower abdomen was observed, and he said it was from the injectable anticoagulant medications. The primary physician for R2 was interviewed on 10/21/15 at 9:45 a.m. and stated that she had been called when the facility noted the error on 10/3/2015 and R2 had not received wafarin since 9/29/2015. An immediate INR protime was completed, the protime was 1.2, which was a risk for R2 because of his history of clots. She stated that R2 was sent to the ER and needed to have Coumadin and an injectable anticoagulant enoxaparin (Lovenox) was given. The additional Lovenox was administered for 10 doses. R2's physician stated that this omission of Coumadin put R2 at a higher risk for developing additional clots, and it was physically uncomfortable for R2 to have additional injectable medication. The nurse manager RN-C stated in an interview at 2:30 p.m. on 10/12/2015 that the orders for wafarin were not entered into the computer correctly for transcription. She stated that some of the orders were misplaced by the health unit coordinator's desk and were not entered timely. She acknowledged that this was not the expected process and that the nurse was re-educated. R3 medical record was reviewed, the September 2015 MAR indicated R3 had diagnoses including atrial fibrillation (a conduction problem of the heart) and a history of blood clots in the legs. R3 had warfarin (Coumadin) an anticoagulant medication ordered daily to prevent blood clots.	21545		

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21545	Continued From page 9 The September MAR for R3 had an order dated 8/28/2015 of warfarin 4 mg until 9/4/2015, and to have an INR done on 9/4/2015. September 2015 MAR did not have documentation of warfarin (Coumadin) given 9/4/15, 9/5/15, and 9/6/15. The nurse progress note dated 9/7/2015 documented R3 "did not have INR checked on 9/4/15 per order, R3 did not receive Coumadin on 9/4/15, 9/5/15, or 9/6/15". The nurse notified the physician, the INR value was checked and wafarin was ordered by the physician. A nurse progress note dated 9/8/2015 indicated there was no adverse effects from the medication error on 9/4/15. The facility policy titled "Adverse Consequences and Medication Errors" dated 2001, noted that a medication error would include an omission for a drug that is ordered but not administered, and the wrong dose given. The orientation and training for nurses included transcription of medication orders on the computer system, and that orders needed to be double checked for accuracy. The DON stated in an interview at 1:15 p.m. on 10/12/2015 that the facility identified errors with transcription of orders on return from the hospital, INR tests being completed, and orders obtained. She stated she had the assistant director of nursing (ADON) send an e-mail to all nurses that included training to double check all orders, and that additional training would be done at the October 2015 nurse's meeting. She stated audits were being done by nurse managers on all resident's on return from the ER or hospital to assure the orders were correct.	21545		

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21545	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The director of nurses or desginee could review pertinent facility polices and the procedures for medication administration, to ensure all medications that are ordered are administered in accordance with the physician orders. The director of nurses or designee could revise the policies as needed to ensure compliance with medication administration. Then develop a change in the system to ensure compliance. Educate the staff on the change in the system. Monitor that change for effectiveness and continue to monitor records to ensure compliance. TIME PERIOD OF CORRECTION: Twenty-one (21) days	21545		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe	21980		

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21980	Continued From page 11 that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to immediately report to the administrator and the state agency (SA) alleged violations of neglect for 2 of 2 (R1 and R2) residents reviewed for significant medication errors that needed medical care.	21980		

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21980	Continued From page 12 Findings include: R1 had a significant medication error that was noted by the facility on 9/23/2015, the incident report noted the error was reported to the Director of Nursing (DON) on 9/23/2015, but was not reported to the state agency (SA) until 9/25/2015. R1's medical record was reviewed. R1 had diagnoses including seizures and head injury, he had resided at the facility for over a year. Review of the medication error report dated 9/23/2015 indicated R1 did not have a seizure medication lacosamide (Vimpat) restarted after an emergency room visit, and missed a total of 9 doses of the medication over 5 days. The DON had been notified on 9/23/2015 at 12 p.m., there was no record of the administrator being notified. The incident was not reported to the SA until 9/25/2015. Progress notes indicated that R1 had several seizures, falls and a change in mental status, and needed to be seen in the emergency room (ER) on 9/20/2015 and hospitalized on 9/23/2015. R2's medical record was reviewed. R2 had diagnoses including primary thrombophilia (blood clots) and a history of pulmonary embolism (blood clot in the lungs). The medication error incident report dated 10/3/2015 indicated R2 did not have warfarin (an anticoagulant medication) restarted at the time he returned to the facility from the hospital for treatment of pneumonia from 9/30/15 until 10/3/15, missing a total of 3 doses. R2 was sent to the ER on 10/3/15 to evaluate the effects of	21980		

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21980	Continued From page 13 missing the medications after an INR protime lab report was too low. The error was discovered on 10/3/2015, and reported to the DON on 10/3/2015 at 3 p.m., the report to the SA was not done until 10/6/2015. There was no record of notification of the administrator. The DON said in an interview at 1:15 p.m. on 10/12/2015 that medication errors were reportable if they were serious and required medical care, and there was no reason given for not reporting immediately to the SA. The facility's "Abuse Prevention Plan" (undated) indicated that the DON was the designated administrator when the administrator was absent from the building, and the facility professional that received the report of maltreatment was responsible for immediately notifying the administrator, and the state agency. The policy indicated that neglect included the failure to provide services necessary to maintain physical health. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the pertinent policies and procedures for reporting, educate the staff on what is reportable, to immediately report to the administrator and the state agency. Then develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21980		

UIIFC

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245227	A. Building B. Wing	1/11/2016

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 F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	12/31/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	12/31/2015	ID Prefix F0333 Reg. # 483.25(m)(2) LSC	12/31/2015
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	

Reviewed By State Agency	Reviewed By MN/mm	Date: 01/19/2016	Signature of Surveyor: 19692	Date: 01/11/2016
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/23/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

OHFC

AH Form Approved
1/15/2016

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00589	A. Building B. Wing	1/11/2016

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 21545 Reg. # MN Rule 4658.1320 A.B.C LSC	Correction Completed 01/11/2016	ID Prefix 21980 Reg. # MN St. Statute 626.557 Sul LSC	Correction Completed 01/11/2016	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MN/mm	01/19/2016	19692	01/11/2016
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/23/2015

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