



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
October 12, 2020

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: September 24, 2020

Dear Administrator:

On September 24, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 24, 2020, the situation of immediate jeopardy to potential health and safety cited at F 600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 27, 2020.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective October 27, 2020 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 27, 2020, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 24, 2020. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been

subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayshore Residence & Rehab Ctr is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 24, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 24, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The

Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltr_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 10/28/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/24/2020
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/22/20, through 9/24/20, a complaint investigation was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F610 related to the facility's failure to thoroughly investigate an allegation of selling and distributing narcotics for 1 of 1 residents (R1) resulting in actual harm to resident health and safety. The IJ began on 9/13/20. The administrator and director of nursing (DON) were notified of the IJ on 9/23/20, at 3:17 p.m. The IJ was removed on 9/24/20, at 3:17 p.m. but non-compliance remained at the lower scope and severity of a G, actual harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted on 9/24/20. The following complaints were found to be SUBSTANTIATED: H5227112C, H5227113C. The following complaint was found to be UNSUBSTANTIATED: H5227114C In addition, an extended survey was completed on 9/24/20, related to the substandard quality of care findings. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are	F 000			

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

TITLE

(X6) DATE

Electronically Signed

10/22/2020

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 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure neglect did not occur when they received reports a resident (R2) was selling his morphine to other residents. This resulted in an immediate jeopardy for R1, when she purchased narcotics from R2, and was sent to the emergency room (ER) with an overdose of narcotics. This had the potential to effect all 99	F 600	CITED R1 signed a behavior contract agreeing not to buy, barter, give, borrow, sell, steal, drugs, alcohol, smoking material, or medication. Facility offered to schedule a Rule 25 assessment for R1. R1 stated she had a		11/3/20

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F 600	Continued From page 2 residents currently residing in the facility. The IJ began on 9/13/20, when R2 was reported to have been selling his prescribed narcotic medications to residents in the facility. The facility failed to act on the allegations. As a result, R1 was sent to the ER for possible narcotic overdose, and was treated with Narcan (medication used for treatment of overdose of opioids). The administrator and director of nursing (DON) were informed of the IJ on 9/23/20, at 3:17 p.m. The IJ was removed on 9/24/20, at 3:12 p.m., but non-compliance remained at the lower scope and severity of a G, actual harm that is not immediate jeopardy. Findings Include: R2's Admission Record printed 9/24/20, indicated R2's diagnoses included alcohol dependence, chronic respiratory failure, and viral hepatitis C. R2's quarterly MDS dated 8/31/20, indicated R2 had mild cognitive impairment, and was administered opioid medication 7 out of 7 days during review period. R2's care plan revised 9/24/20, directed staff to notify supervisor if illegal drug or alcohol use was suspected, then two staff should complete a room search and remove any alcohol or drugs from his room. Supervisor should notify physician if illegal drug or alcohol use was suspected. R2's Physician Orders dated 9/14/20, included Roxanol (morphine liquid concentrate) 20 milligrams/milliliter (mg/ml) administer 1 ml orally every 1 hour as needed for pain and shortness of breath, and morphine sulfate extended release	F 600	Rule 25 assessment done in the past and did not want to do it again. R1 did not want to transfer to a chemical dependency facility. R2 signed a behavior contract ensuring that medications will be swallowed as given. R2's physician directed facility to decrease Morphine ER 60mg from three times per day to two times daily with follow up 9/29/20 for further taper. Order was entered into EMAR and confirmed by nurse 9/23/20 at 1139. 10/7/20 MD changed order to 30mg morphine sulphate tablet 30mg TID. 'Ensure mouth checks are performed with each med pass' added to R2's MAR 9/14/20 at 1205. 'Perform mouth checks with every med pass to ensure resident is taking his medications and not cheeking' added to R2's care plan 9/24/20. 9/21/20 Duluth Police Department notified of the incident. 10/1/20 DPD on-site to investigate. Investigation still pending. At Like: Facility completed 'IJ Abatement 9/23/20' questionnaire with all residents to assure pills were not being shared/sold/bartered between residents. Facility identified no residents currently possess narcotics. A room search was completed on the two		

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F 600	Continued From page 3 (ER) tablet 60 milligrams (mg) with instructions to give 1 tablet by mouth three times a day for pain and and staff could not give MS ER and Roxanol at the same time, but must wait at least one hour after MS ER 60 mg tablet for MS solution. Please place this medication in separate cup and perform mouth check. R1's Admission Record printed 9/24/20, indicated R1's diagnoses included history of opioid use with intoxication, alcohol dependence, cerebral infarction, and acute cystitis (kidney infection). R1's annual Minimum Data Set (MDS) dated 6/29/20, indicated R2 had no cognitive impairment, and had no opioid medications administered during 7 day review period. R1's care plan initiated 2/14/18, indicated R1 was known to have and ingested illegal substances. Interventions included: if illegal drug or alcohol use is suspected, notify supervisor, then two staff should complete a room search and remove any alcohol or drugs from her room. Supervisor should notify physician. On 9/13/20, R2's progress note indicated R7 had reported to nursing staff that R2 had been saving his morphine tablets and giving them to residents. R2's progress note further indicated, "just to be on the safe side" R2's morphine was to be put into a separate med cup by itself, and then given to R2 to ingest. R2 was informed of the new administration method for controlled substances, and this procedure was to ensure that resident were taking their medications. The progress note lacked indication if an investigation had been done to see if R2 had been giving other residents his narcotics.	F 600	identified residents from the 'IJ Abatement 9/23/20' questionnaire. No pills or illegal substances were found. Education: Director of Finance, Director of Admissions and Marketing, Director of Nursing, First Floor Nurse Manager, Medical Record Coordinator, Administrator, First Floor Social Worker, Director of Social Services, Park Breeze Nurse Manager, Recreation Director, Human Resources Coordinator, Dietary Director, MDS Coordinator, Harbor light Nurse Manager, Therapy Director, Maintenance Director, ADON, and Environmental Services Director have reviewed the CMS - State Operations Manual Interpretive Guidelines for F600. All nurses and TMA's were re-educated to ensure residents are swallowing their medications. Audits: Facility will complete R1 and R2 room searches twice weekly for two weeks, weekly for four weeks, then monthly for three months to assure compliance. Facility will audit med pass of residents with mouth checks to assure pills are being administered properly and swallowed. Audits will be completed twice weekly for two weeks, weekly for four weeks, then monthly for three months to assure compliance. Audit findings will be reported monthly to the QAPI Committee for review and follow up		

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F 600	Continued From page 4 On 9/16/20, R1's progress note indicated R1 was unable to keep her eyes open, she was lethargic, warm to the touch, and the right side of her face was drooping. An order was obtained and R1 was sent to the ER. On 9/21/20, R1's Patient Discharge Orders from the hospital included opioid intoxication as the principle active diagnosis. On 9/21/20, R1's progress note indicated R1 returned from the hospital and had tested positive for opioid use. R1 also had a diagnosis of urinary tract infection. R1 was re-admitted to the facility into a different room. The progress note indicated R1 had requested staff to go to her previous room to get her money, and when staff went to the room, they discovered a MS 60 mg tablet wrapped inside of R1's money. Staff brought the MS tablet to the administrator. An undated facility incident report indicated on 9/21/20, staff had found a tablet in R1's previous room. The tablet was identified as MS 60 mg. R2 was identified as the only resident on the unit who was prescribed 60 mg MS. The administrator, registered nurse (RN)-A, and maintenance staff preformed a complete room safety check of R2's room. During R2's room search, staff located a cigarette pack filled with what RN-A conformed to be MS 60 mg tablets. R2 denied selling or sharing his medications at that time. Law enforcement was notified of the findings, as were both R1 and R2's physicians. An undated facility document signed by the administrator indicated 159 MS 60 mg tablets were found stored inside a cigarette package,	F 600	recommendations. The QAPI Committee will determine when the audits may be discontinued. Director of nursing and or designee is responsible for compliance.		

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F 600	Continued From page 5 and were recovered from R2's personal locked drawer on 9/21/20. On 9/22/20, at 2:04 p.m. the administrator was interviewed and stated on 9/13/20, R7 made the allegation that R2 was selling his medications to R5. The administrator stated at that time, both R2 and R5 were interviewed, and both denied sharing/selling of any medications. The administrator stated both R2 and R5 had room searches completed, however, staff had not searched R2's lockbox at that time. The administrator stated the facility tried to respect the privacy of R2 at the time of 9/13/20, incident. The administrator stated no additional steps were taken to investigate the allegation of possible selling of medications on 9/13/20, nor was this alleged incident reported to the State Agency (SA). The administrator stated on 9/21/20, a MS 60 mg tablet along with money was found in R1's room. The administrator stated neither R1 nor R2 would give information about the MS 60 mg tablet found in R1's previous room when interviewed. The administrator stated because R2 had money, and R1 was previously on R2's unit, it was assumed the pills found came from R2. The administrator stated R2 was the only resident in the facility with an order for MS 60 mg tablets, which was the same medication found R1's previous room. The administrator verified a total of 159 MS 60 mg tablets were found in R2's room in his locked drawer. On 9/22/20, at 2:52 p.m. R2 was interviewed and stated he had been saving his noon MS 60 mg dose in his mouth after staff administered it to him. R2 stated he would then put the medication in his lockbox. R2 stated he had been doing this for months and months. R2 stated he did not sell	F 600			

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

PRINTED: 10/28/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/24/2020
NAME OF PROVIDER OR SUPPLIER BAYSHORE RESIDENCE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 ST LOUIS AVENUE DULUTH, MN 55802		
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F 600	Continued From page 6 his morphine to other residents, but stated his friends knew where they were, and "maybe they just came in and got a pill or two." R2 stated R1 knew of the pills in his lockbox, and stated R1 may have went into his room and taken the pills herself. On 9/23/20, at 7:47 a.m. R1 was interviewed and stated she had purchased the morphine that resulted in her overdose from R2. R1 stated she had been given Narcan in the ER for opioid overdose. R1 stated she had only purchased one tablet from R2 on 9/16/20. R1 stated she had purchased another morphine from R2 previously, and this was the pill that was found in her room. R1 stated she had no plan to purchase additional pills from R2 again, especially since she was no longer on R2's unit. On 9/23/20, at 9:02 a.m. R7 refused to be interviewed. On 9/23/20, at 9:30 a.m. R6 was interviewed and denied knowing R2. R6 stated he knew nothing about R2 selling or trying to sell his medications. R6 further stated he had his own medications and he did not need to take anyone else's. On 9/23/20, at 9:36 a.m. trained medication aide (TMA)-A stated R2 was now required to have a mouth check completed to ensure he swallowed his medications. TMA-A stated R2's MS 60 mg tablet was also now placed in a separate pill cup for administration. TMA-A stated after R1's overdose, R2 told her he had been cheeking (storing in his mouth) and saving his noon MS 60 mg dose. On 9/23/20, at 11:07 a.m. RN-A stated on	F 600			

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F 600	Continued From page 7 9/13/20, R7 made an allegation that R2 was selling his medications. RN-A stated R7 was considered an unreliable source. RN-A stated the facility interviewed R2, R5, and R7 after the allegation. RN-A stated they had not searched R2's lock box on 9/14/20, nor had they interviewed residents known to associate with R2. RN-A stated he was working the day R1 was sent to the ER. RN-A stated R1 appeared intoxicated, but he did not smell alcohol on R1 at that time. RN-A stated he called the ER and requested they conduct a toxicity screen for possible drug use. RN-A stated he went into the hospital electronic record on 9/17/20, and R1's record indicated she had tested positive for opioids. RN-A stated the administrator was made aware of R1's opioid use on 9/17/20. RN-A stated the facility had not completed a search for additional pills in R1's room, nor did they conduct an investigation after learning R1 tested positive for opioids. RN-A further stated the facility had not made a report to the SA until 9/21/20, when the additional morphine tablet was found in R1's personal belongings. RN-A stated at that time, the facility searched R2's room. RN-A stated during R2's room search, the facility also searched R2's lockbox. RN-A stated R2's lockbox contained 159 MS 60 mg tablets in a cigarette pack. RN-A stated both R1 and R2 denied sharing or selling medications when interviewed by facility. RN-A stated law enforcement was called and informed of the 159 MS 60 mg tablets in R2's possession. RN-A stated R2 had a current diagnosis of hepatitis C, and R1 had not been tested for hepatitis C from sharing medications that had been in R2's mouth. On 9/23/20, at 2:26 p.m. the emergency room physician (MD)-A was interviewed. MD-A stated	F 600			

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F 600	Continued From page 8 immediately upon her arrival to the ER, R1 required 2 doses of Narcan be administered immediately. MD-A stated R1's hospital admission diagnosis included opioid intoxication. On 9/24/20, at 4:10 p.m. the director of nursing (DON) stated on 9/13/20, a concern was brought to their attention related to R2 selling his medications. The DON stated on 9/14/20, the administrator had searched R2's room, however, R2's lockbox had not been searched at that time. The DON stated residents known to associate with R2 were not interviewed or educated on the risk of taking medications not prescribed to them. The DON stated she had no involvement or conversation with R2 at that time. The DON stated she was not involved in sending R1 to the ER on 9/16/20. The DON stated at morning meeting on 9/17/20, RN-A informed her and the administrator R1 had tested positive for opioids. The DON stated at that time, no investigation was initiated by the facility to identify where R1 obtained opioids. The DON stated on 9/21/20, the day additional pills were found in both R1 and R2's possession, she was not working. The DON stated when interviewed by staff, both R1 and R2 denied selling or sharing or medications. The DON stated, "We are not a jail, and people can make poor choices." The DON stated the facility should have completed an investigation after the allegation on 9/13/20, and after R2's opioid overdose on 9/16/20. The DON stated failure to properly investigate and educate all residents could have resulted in additional residents taking medications not prescribed to them, resulting in harm. The facility implemented corrective action to prevent recurrence by 9/23/20. The facility	F 600			

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F 600	Continued From page 9 completed a questionnaire with all residents to assure pills were not being shared/sold/bartered between residents. The facility identified no residents currently possessed narcotics. The facility completed room searches on R1 and R2, and no medications were found. R1 signed a behavior contract agreeing not to buy, barter, give, borrow, sell, steal, drugs, alcohol, smoking material, or medication. In addition, R2 signed a behavior contract ensuring that medications will be swallowed as given. R2's physician directed the facility to decrease his Morphine ER 60 mg from three times per day, to two times daily, and to follow up 9/29/20, for further taper. The order was entered into R2's medical record. All nurses and TMA's were re-educated to ensure residents were swallowing their medications. The corrective actions were verified by interviews with staff, and document review. On 9/23/20, and 9/24/20, law enforcement was called. Messages were left, however, there was no return call. The facility policy Administering Medications dated 11/20/19, directed medications ordered for a resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing Services.	F 600			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 12, 2020

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Re: Event ID: FWSQ11

Dear Administrator:

The above facility survey was completed on September 24, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/24/2020
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/22/20, through 9/24/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure. The following complaints were found to be SUBSTANTIATED: H5227112C, H5227113C.	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

10/22/20

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H5227114C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000			