



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2021

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

RE: CCN: 245227
Cycle Start Date: July 1, 2021

Dear Administrator:

On July 20, 2021, we informed you of imposed enforcement remedies.

On August 20, 2021, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is/are as follows:

F0725 -- S/S: D -- 483.35(a)(1)(2) -- Sufficient Nursing Staff

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 4, 2021, will remain in effect.

This Department continues to recommend 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 August 4, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 4, 2021.

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.

As we notified you in our letter of July 20, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 4, 2021. However, due to the extended survey the new NATCEP loss date is July 1, 2021.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

**Susan Frericks, 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: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 - Health Regulation Division 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 January 1, 2022 (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

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.

INFORMAL DISPUTE RESOLUTION/ 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/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

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,

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
July 20, 2021

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

RE: CCN: 245227
Cycle Start Date: July 1, 2021

Dear Administrator:

On July 1, 2021, 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 July 1, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 August 4, 2021.

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 August 4, 2021(42 CFR 488.417 (b)). They will also notify the

State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 4, 2021 (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 July 1, 2021. 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 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 July 1, 2021. 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:

Terri 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
Office: (218) 302-6151 Mobile: (218) 766-2720

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 January 1, 2022 (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/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
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: 07/28/2021
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 07/01/2021	
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 6/28/21, through 7/1/21, 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 F698 related to the facility's failure to notify the designated family member representative, healthcare agent and physician for refusal of dialysis, medications and paracentesis for (R1) resulting in actual harm to resident health and safety. The IJ began on 5/28/21. The administrator and director of nursing (DON) were notified of the IJ on 6/31/21, at 4:18 p.m. The IJ was removed on 7/1/21, at 2:08 p.m. but non-compliance remained at the lower scope and severity of a D, potential for more than minimal harm. An extended survey was also completed. The following complaints were found to be SUBSTANTIATED: H5227137C (MN74150). Deficiencies were issued at F698 H5227138C (MN74200). A deficiency was issued at F725. H5227139C (MN73319). A deficiency was issued at F725. H5227140C (MN71966). A deficiency was issued at F725.			F 000			

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

TITLE

(X6) DATE

Electronically Signed

07/23/2021

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.

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

PRINTED: 07/28/2021
FORM APPROVED
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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 07/01/2021
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	Continued From page 1 In addition, additional deficiencies were cited at F550 and F732. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are 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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550			7/29/21

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

PRINTED: 07/28/2021
FORM APPROVED
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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 07/01/2021	
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 550	Continued From page 2 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all residents had reasonable access to the use of a telephone for outgoing calls for 3 of 4 residents (R5, R12, R13) reviewed due to concerns related to facility phones not in working order in all resident rooms. In addition, facility staff lacked the ability to call out on facility phones on the dates of 6/10/21, through 6/18/21. This had the potential to affect all 94 residents who resided in the facility. Findings include: On 6/28/21, at 3:38 p.m. nursing assistant (NA)-A was interviewed and stated the phones in the facility had not been working for at least 3 weeks.			F 550	F 550 R5, R12 and R13 met with the social services director and was educated on the emergency use cell phone and its location. Their response will be documented in the resident electronic medical record. For current residents, the facility staff will assist the resident to make a private outgoing call. For future resident admits, residents will have use of the assigned room phone and/or assistance by staff and in emergencies the facility cell phone will be activated and a mass message will be sent to resident representatives via the facility mass message module.		

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F 550	Continued From page 3 NA-A stated calls can come into the facility, but staff and residents were not able to make outgoing calls. NA-A stated staff were using their personal cell phones to call for emergencies, pharmacies, providers and hospitals. NA-A stated residents also have shared their frustration of not being able to use the facility phones. On 6/28/21, at 9:20 a.m. trained medication aid (TMA)-A stated the facility phone could only receive calls and there was not ability to make outgoing calls. TMA-A further stated if she needed to make a call, she would need to go into the employee breakroom and get her personal cell phone. TMA-A stated management had not spoken to her about the facility phones not working. On 6/29/21, at 9:21 a.m. R11 was interviewed and stated she uses the phone in her room to call her family. R11 stated she was not sure if the phones were working and wheeled herself via wheelchair to her bed, listened for a dial tone and dialed a number. After dialing a number, a busy dial tone was heard. R11 stated, "Isn't it funny whoever I am calling the line is busy." R11 further stated she gets a busy tone frequently but would try her call again later. On 6/28/21, at 9:24 a.m. licensed practical nurse (LPN)-A stated the both the phone and fax lines were not working. LPN-A stated if they need to make a phone call, staff had to use their personal cell phones. LPN-A stated the facility had been able to receive calls, but could not make calls. LPN-A stated the facility could not send out a fax. On 6/28/21, at 9:40 a.m. the director of maintenance (DM)-A stated the phones had not	F 550	Facility staff were in-serviced on the use of the emergency use cell phone. Social services and/or designee will be in-serviced on notification to families and resident representatives utilizing the mass message module. Facility staff will also review the Resident Right Policy and Procedure with emphasis on item #cc that residents have the right to use of a telephone, email and mail. Residents will be educated how staff can assist with an outgoing phone call and the facility mass communication notification. Facility has worked with five hardware/software/internet/phone service provider companies to temporarily reconfigure the system to be fully functional. New phone hardware and software installation will begin the week of August 9th. Social services and/or designee is responsible for compliance. Audits on resident knowledge of the emergency phone and facility phone service will begin 2x week for 2 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/29/2021		

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F 550	Continued From page 4 been working correctly, but the administrator had recently sent out an email. The email contained a code staff could use to make calls from the nurse's station to be able to call out. DM-A stated the code only worked from the nurse's station phones, and would not work for phones in resident rooms. On 6/29/21, at 9:46 a.m. the administrator stated the inability to make outgoing calls and send faxes started on 6/10/21. The administrator stated neither the residents nor family member were notified that no outgoing calls could be made. The administrator stated no direction was put out for staff to use their personal cell phones if a call needed to be made, the information had just been shared with staff during shift changes. The administrator stated emails had been sent to staff regarding the phone system being down and the inability to make outgoing calls, however, no instruction for using personal cell phones were included in those emails. The administrator stated the inability to make outgoing calls only affected R5, R12, and R13, as all other residents had other forms of communication such as personal cell phones. A policy on phone use was requested but not provided.	F 550			
F 698 SS=J	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698			7/29/21

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F 698	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the health care power of attorney (POA) and the primary care provider (PCP) of refusals of dialysis, medications, and paracentesis for 1 of 3 residents (R1) reviewed for dialysis. This resulted in an immediate jeopardy (IJ) when R1 refused dialysis, medications, and paracentesis, and the facility did not notify the health care POA or the physician, and R1 subsequently died. The IJ began on 5/28/21, when R1 began refusals of dialysis, medications, and paracentesis. The administrator and director of nursing (DON) were notified of the IJ on 6/30/21, at 4:18 p.m. The IJ was removed on 7/1/21, at 2:08 p.m. but non-compliance remained at the lower scope and severity of a D, potential for more than minimal harm. Findings Include: R1's Admission Record printed 7/1/21, indicated R1 was admitted to the facility on 5/27/21, with diagnosis that included cirrhosis of liver (liver damage leading to scarring and liver failure), end stage kidney disease, septicemia (infection in the blood stream), spontaneous bacterial peritonitis (infection of the inner abdominal wall), hepatic encephalopathy (loss of brain function when a damaged liver doesn't remove toxins from the blood) and chronic pancreatitis (inflammation of the pancreas). R1's admission Minimum Data Set (MDS) dated 6/1/21, indicated R1 had no cognitive impairment, had complex medical conditions, required dialysis	F 698	F 698 R 1 was transferred out of facility on 6/7/21 to acute care hospital where she died on 6/9/21. Current residents receiving dialysis services charting was reviewed from 5/28/2021 □ 7/22/21 and there were no refusals to go to dialysis on their scheduled days. Future resident admissions who require dialysis and refuse services, the MD, family representative and dialysis company will be notified. Nursing staff were education on 6/30/2021 and again on 7/2/2021 on the Refusal of Treatment policy, the resident response and reason/reasons for refusal, notification to the resident representative and documentation reflected in the resident electronic medical record. Director of Nursing and/or designee is responsible for compliance. Audits on refusal of care and MD and resident representative notification will begin 3x week x 2 weeks, 2x week for 4 weeks, weekly x 4 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/29/2021		

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F 698	Continued From page 6 (acts as the kidneys, filtering and purifying the blood using a machine), required paracentesis (procedure in which fluid is removed from the abdominal cavity), and required extensive assistance with activities of daily living (ADLs). R1's MDS also indicated she had rejection of care 1-3 days in the past 7 days. R1's baseline care plan initiated 6/2/21, lacked indication R1 received dialysis and had daily paracentesis. The care plan also lacked interventions for rejection of treatments and medications. R1's Physician Orders dated 5/27/21, included an order for dialysis on Monday, Wednesday, and Friday, PleurX abdominal drain (for paracentesis) to be drained one time daily at 8:00 p.m., Cipro (antibiotic) 250 milligram (mg) po (by mouth) one time daily, Lactulose (encephalopathy treatment) 20 grams (gr) per 30 milliliters (mls) 20 gr by mouth one time daily, Creon (pancreatitis medication) capsule 24000-76000 units 2 capsules by mouth three times a day, Renal Capsule (vitamin) 1 mg once daily, and Midodrene (to treat low blood pressure) 10 mg by mouth three times daily. On 6/29/21, at 8:39 a.m. R1's family member (FM)-A was interviewed and stated she had faxed the facility the paperwork which indicated FM-A was R1's POA for health care. FM-A stated R1 had been receiving dialysis prior to being admitted to the nursing home, and she also required paracentesis. FM-A stated R1 had never refused dialysis treatments while in the hospital prior to her nursing home stay. FM-A stated R1 had told her she wanted to continue the dialysis to extend her life, to see her grandchildren grow	F 698			

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F 698	Continued From page 7 up. FM-A stated she had told the facility if R1 became confused, it was a change in condition for her. FM-A stated the facility had not notified her of R1's refusals of dialysis, medications, or paracentesis. FM-A stated had she been notified, she would have gone to see R1 to make sure this was what R1 wanted. On 6/4/21, a progress note indicated R1 refused to go to dialysis. The progress note lacked indication if R1's primary care provider (PCP) or FM-A were notified. R1's medical record lacked any further documentation of when she did not attend dialysis. The dialysis center provided the following information: On 6/2/21, an Absence and Hospitalization Record indicated R1 did not receive dialysis that day. On 6/4/21, an Absence and Hospitalization Record indicated R1 did not receive dialysis that day. On 6/7/21, an Absence and Hospitalization Record indicated R1 did not receive dialysis that day. Review of R1's June 2021, and July 2021 Medication Administration Record (MAR) indicated the following: PleurX abdominal drain (paracentesis) had been refused on 5/28/21, 5/30/21, 5/31/21, 6/3/21, and 6/5/21. Cipro 250 mg po daily had been refused on	F 698			

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F 698	Continued From page 8 5/27/21, 5/28/21, 5/29/21, and 6/3/21. Lactulose 20 gr per 30 mls, 20 gr once daily had been refused on 5/28/21, 5/31/21, 6/3/21, 6/5/21, 6/6/21 and 6/7/21. Creon capsule 24000-76000 units ordered for 2 capsules 3 times a day had been refused on 5/28/21, 2 doses; 5/29/21, 1 dose; 5/30/21, 2 doses; 6/2/21, 2 doses; 6/3/21, 2 doses; 6/4/21, 2 doses 6/5/21, 3 doses; 6/6/21, 1 dose; and 6/7/21, 1 dose. Renal Capsule 1 mg once daily had been refused on 5/28/21, 5/29/21, 5/30, and all days from 6/2/21, through 6/6/21. Midodrene 10 mg three times a day had been refused on 5/28/21, 2 doses; 5/29/21, through 6/4/21, 1 dose each day; 6/5/21, 2 doses; 6/6/21, 1 dose; and 6/7/21, 2 doses. R1's medical record lacked documentation if FM-A or R1's PCP were notified of R1's refusal of medications. A Physician Visit Report dated 6/3/21, written by nurse practitioner (NP)-A indicated R1 allowed the PleurX drain to be drained today. The report further indicated R1 was tolerating medications. The report lacked indication of R1's refusal of dialysis or refusal of medications. On 5/27/21, at 9:43 p.m. a progress note indicated FM-A had called to check on R1, and stated that she was R1's POA for health care decisions. FM-A stated she would be faxing the paperwork in the morning.	F 698			

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F 698	Continued From page 9 On 5/29/21, at 5:18 p.m. a progress note indicated R1 refused to let the nurse look at her drain. R1 stated, "It is just fine." The progress note lacked indication if FM-A or R1's PCP were notified of R1's refusal. On 5/29/21, at 6:33 p.m. a progress note indicated R1 had been refusing "just about everything." R1 would not let the nurse look at her PleurX drain. R1 stated it was "just fine" and did not need to be emptied. R1 was also refusing most of her pills and meals. The note indicated FM-A would be called and updated. The progress note lacked indication if R1's PCP was notified, and lacked indication if FM-A had been called. On 6/1/21, at 4:16 p.m. a progress note indicated R1 had been refusing some of her medications, and had been refusing the PleurX drainage over the last three days. The note indicated the refusals were discussed with R1. R1 had been having some difficulty breathing due to the increase of abdominal fluid buildup. The note indicated the physician would be notified, but lacked indication if he/she was. The note also lacked indication if FM-A was notified. On 6/3/21, at 9:19 p.m. a progress note indicated R1 stated, "It (paracentesis) was drained yesterday and does not need to be done today." The progress note lacked indication if R1's PCP or FM-A were notified of R1's refusal. On 6/7/21, at 3:59 a.m. a progress note indicated R1 was yelling, "Help me" holding onto her abdomen. R1 reported severe pain in her abdomen. Used PleurX drainage system to remove 1100 ml of fluid. Administered as needed (PRN) Oxycodone (narcotic pain medication) 10	F 698			

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F 698	Continued From page 10 mg with effective results. On 6/7/21, at 1:35 p.m. a progress note indicated staff had entered R1's room at 12:15 p.m. to deliver lunch. R1 was lethargic, weak, pale in appearance and dusky in color. R1's respirations were shallow, and her abdomen was distended due to fluid overload. R1 refused dialysis on Friday 6/4/21, and again today. R1 had also been refusing many of her medications and her PleurX. R1 was requesting to go to the hospital. R1 had a full code resuscitation status. FM-A and R1's physician were notified, and R1 was sent to the emergency department (ED) via ambulance. On 6/7/21, an ED note indicated R1 apparently voluntarily skipped dialysis last week. R1 was noted to be hypotensive (low blood pressure) in the nursing home and was sent to the ED for evaluation. The note further indicated upon arrival to the ED, R1's blood pressure was very low, R1 was listless, and minimally responsive. R1's abdomen was slightly distended, and a PleurX catheter was noted in the right abdomen. On 6/9/21, at 6:57 p.m. a progress note indicated the hospital had called and informed the facility R1 had expired at 6:25 p.m. On 6/30/21, at 10:23 a.m. the director of nursing (DON) was interviewed and stated she would have expected FM-A and R1's PCP to have been notified of R1's refusal to go to dialysis, and her refusals of paracentesis and medications. The DON verified staff did not consistently document R1's refusals of dialysis, paracentesis or medications, and she would expect them to. On 6/30/21, at 2:55 p.m. NP-A was interviewed	F 698			

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F 698	Continued From page 11 and stated he had only seen R1 as a patient one time on 6/3/21. NP-A stated the facility had reached out to him on 6/2/21, with concerns related to R1's refusal of the paracentesis. NP-A stated if a resident refused cares or treatments, he would expect to be notified. The facility policy Dialysis Care dated 2/12/20, directed any significant change in the resident's status related to clinical complications or emergent situations, the nursing home staff will communicate with and notify the attending physician/practitioner, resident/resident representative and dialysis staff. This notification will be documented in the resident's electronic medical record. Refusal of treatment, missed appointments, canceling or postponing treatment, the nursing home staff will contact the dialysis and will begin daily observation and medical management until dialysis is rescheduled/resumed. The facility policy Refusal of Treatment updated 6/30/21, directed "Treatment" is defined as a care provided for purposes of maintaining/restoring health, improving health, improving function level, or relieving symptoms. The policy directed staff if a resident refuses treatment, the unit manager, Charge Nurse, or Director of Nursing Services will interview the resident to determine what and why the resident is refusing in order to address the residents concern and explain the consequences of the refusal. If a resident's refusal brings about a significant change, a reassessment will be made, and such information will be incorporated into the resident's care plan. The policy further directed staff that documentation of the refusal of treatment include that the resident was informed of the purpose of the treatment and the	F 698			

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F 698	Continued From page 12 consequences of not receiving the medication/or treatment as well as the date and time the physician and resident representative was notified as well as the physician's response to the refusal. The immediate jeopardy that began on 5/27/21, was removed on 7/1/21, at 2:08 p.m. when the facility completed an audit of all resident records to ensure physicians and if applicable residents designated representative had been notified of all recent refusals of dialysis, physician ordered treatments and medications. In addition, all licensed staff members were re-educated on what steps to take if residents had a refusal of dialysis, physician ordered treatments and or medications. These actions were verified through interview and record review.	F 698			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 725			7/29/21

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F 725	Continued From page 13 (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient nursing staff to provide and meet the needs for 4 of 6 residents (R4, R6, R9 and R10) reviewed for activities of daily living (ADLs). Findings include: R4's Admission Record printed 7/1/21, indicated R4's diagnoses right sided paralysis and weakness related to stroke, morbid obesity, and depression. R4's quarterly Minimum Data Set (MDS) dated 6/12/21 indicated R4 was cognitively intact, required extensive assistance with activities of daily living (ADLs) including bathing, toileting and transfers using a mechanical lift. R4's MDS also indicated no rejection of cares or services. R4's care plan initiated 5/23/2014, indicated R4 was extensive assist to totally dependent on staff for showers. R4's care plan further indicated R4's wishes were to be showered three times per week on afternoon shift. R4's Task Sheet printed on 7/1/21, indicated R4 had only received a shower for the entire month	F 725	R4 received a shower on 7/2/2021, R6 received a shower on 7/2/2021, R9 received a shower on 7/11/21 and R10 received a shower on 7/1/2021. R4, R6, R9 and R10's ADL care plan for showers were reviewed and bathing preferences were updated as needed. All other resident's desire for bathing preferences were reviewed and updated as needed. Future resident bathing preferences will be obtained upon admission. Nursing staff will be in-serviced on the Shower/Tub Bath Policy and procedure with focus on all items under documentation and reporting. Nurse aides will be responsible for reporting refusals to the assigned nurse and alternative interventions will be explored by IDT team. The facility leadership along with the corporate recruitment team have and continue to diligently seek talent to support and retain staff at the facility. Our efforts include referral, retention and shift bonuses, flexible schedules, higher hourly rates for licensed RN's, and staff appreciation days. Our plan is to expand our nursing staff as candidates apply and are trained.		

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

PRINTED: 07/28/2021
FORM APPROVED
OMB NO. 0938-0391

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F 725	Continued From page 14 of June, 2021. On 6/12/21, at 10:06 p.m. a progress note indicated R4's weekly vitals and skin assessment had not been completed due to R4 not having a shower. The progress note lacked why R4 did not receive a shower. On 6/19/21, at 2:30 p.m. a progress note indicated R4's weekly vials and skin assessment had not been completed due to short staffing. On 6/29/21, at 11:09 a.m. R4 was interviewed and stated she recalled waiting for over a half hour on her commode waiting for staff to return and assist her with toileting. R4 stated she had sat there so long her legs felt weak and she could barely stand after sitting on the commode for that amount of time. R4 stated the facility did not have enough staff, and there were times there had only been one nursing assistant for all residents on her unit. R4 further stated she was scheduled to receive showers three times weekly, but had not been getting them. R6's Admission Record printed 7/1/21, indicated R6's diagnoses included weakness and need for assistance with personal cares. R6's quarterly MDS dated 5/4/21, indicated R6 was cognitively intact, and required extensive assistance with ADLs including bathing, toileting and with transfers using a mechanical lift. R6's MDS also indicated no rejection of cares or services. R6's care plan dated 2/4/21, indicated R6 required assistance from 1 to 2 staff for transfers with mechanical lift and limited assistance of one	F 725	The Director of Nursing and/or designee is responsible for compliance. Audits on resident bath acceptance and bathing refusal documentation will begin 2x week for 2 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/29/2021		

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F 725	Continued From page 15 staff for bathing/showering. The facility Weekly Shower Schedule dated 6/11/21, indicated R6 was to have showers on Sundays and Wednesdays on the afternoons (PM) shift. R6's Task Sheet printed on 7/1/21, indicated R6 had not received a shower for the entire month of June, 2021. On 6/2/21, at 10:09 p.m. a progress note indicated R6's weekly vials and skin assessment had not been completed due to no shower because of short staffing. On 6/23/21, at 10:16 p.m. a progress note indicated R6's weekly vials and skin assessment had not been completed due to not being given a shower. The progress note lacked indication of why R6 was not given a shower. On 6/30/21, at 8:21 a.m. R6 was interviewed and stated the facility had been short staffed. R6 stated she had not been receiving her scheduled showers due to the facility being short staffed. R6 further stated it took two staff to get her up out of bed, and she could wait for over an hour for staff to come and get her up. R9's Admission Record printed 7/1/21, indicated R9's diagnoses multiple sclerosis (disease that damages the cells in the brain and spinal cord) and muscle weakness. R9's quarterly MDS dated 6/5/21, indicated R9 was cognitively intact and was dependent on staff for assistance with ADLs including bathing, toileting and transfers using a mechanical lift.	F 725			

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F 725	Continued From page 16 R6's MDS also indicated no rejection of cares or services. R9's care plan dated 10/11/2018, indicated R9 required one staff assist and a mechanical lift to transfer to the shower chair, and one staff to participate with bathing. R9's care plan further indicated R9's wishes were to be showered three times per week on day shift. The facility Weekly Shower Schedule dated 6/11/21, indicated R9 was to have showers on Sundays, Wednesdays, and Friday on day shift. R9's Task Sheet printed on 7/1/21, indicated R9 had received a shower on 6/9/21, and no other times in June, 2021. On 6/4/21, at 1:00 p.m. a progress note indicated R9's weekly vials and skin assessment had not been completed due to no shower because of short staffing. On 6/18/21, at 2:11 p.m. a progress note indicated R9's weekly vials and skin assessment had not been completed due to no shower because of short staffing. On 6/30/21, at 8:11 a.m. R9 was interviewed and stated she was not getting a shower like she should. R9 stated it had been a while since the staff had been giving her scheduled showers. R9 stated the evening before, there had only been two staff working, and that was not enough to help all the residents on the unit. R9 stated she had also waited a long time for staff to answer her call light. R10's Admission Record printed 7/1/21, indicated	F 725			

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F 725	Continued From page 17 R10's diagnoses quadriplegia (paralysis of all four limbs), muscle weakness and pressure ulcer to right and left buttocks. R10's quarterly MDS dated 5/31/21, indicated R10 was cognitively intact, and required extensive assistance from staff with ADLs including bathing, toileting, and transfers using a mechanical lift. R10's MDS also indicated no rejection of cares or services. R10's care plan dated 11/19/2018, indicated R10 required one staff assist and a mechanical lift to transfer to his personal shower chair and one staff to participate with bathing. R9's care plan further indicated R9's wishes were to be showered three times per week on day shift. The facility Weekly Shower Schedule last undated 6/11/21, indicated R10 was to have showers on Mondays, Thursdays, and Saturdays on evening shift. R10's Task Sheet printed on 7/1/21, indicated R10 had received a shower on 6/3/21, and no other times the month of June, 2021. On 6/12/21, at 10:01 p.m. a progress note indicated R10's weekly vials and skin assessment had not been completed due to R10 not receiving a shower. The progress note lacked indication of why R10 had not received a shower. On 6/30/21, at 8:18 a.m. R10 was interviewed and stated he had not been getting his scheduled showers for weeks at a time. R10 further stated there were "big problems" with staffing, and long call light wait times.	F 725			

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F 725	Continued From page 18 On 6/29/21, at 3:38 p.m. nursing assistant (NA)-A stated there had been times there had been only one NA per unit at the facility. NA-A stated the facility management was aware of the short staffing, but nothing had changed. NA-A stated even at times with two staff working there was not enough help to provide the cares the residents needed. On 6/30/21, at 7:33 a.m. NA-F stated it was impossible to get everything completed such as answering call lights, toileting, and giving showers. NA-F further stated other staff have voiced the same concerns about not being able to provide resident care but nothing was done. On 6/30/21, at 1:25 p.m. NA-B stated she had worked a 16 hour day on 6/29/21. NA-D stated she had been the only NA working in the facility from 10:00 p.m. until 12:00 midnight. NA-D stated the licensed nurses do try to help the NAs, but all cares still had not been able to be provided to the residents. NA-D stated showers were not able to be given due to current staffing. NA-D stated they try to get repositioning and toileting completed timely, but were not able to do it. On 6/30/21, at 11:35 a.m. the administrator was interviewed. The administrator stated he felt staff were able to give the residents the care they required such as showers, but felt the concern was staff were not documenting when they provided the cares. On 7/1/21, at 8:17 a.m. the both the director of nursing (DON) and administrator were interviewed. The administrator stated the facility had been continuing to take admissions even though there had been staffing issues. The	F 725			

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F 725	Continued From page 19 administrator stated the facility had been working on the staffing problem. The administrator stated he had been aware of residents missing showers some day,s but the residents who were vocal about not getting showers were getting them. The administrator stated if residents and staff were verbalizing concern that showers were not being completed, that would be a staffing concern. The facility policy Facility Assessment undated, directed the facility will conduct, document, and annually review a facility wide assessment, which included both their resident population and the resources the facility needs to care for the residents. The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations as well as emergencies and to provide person centered care and services required.	F 725			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732			7/29/21

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F 732	Continued From page 20 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, failed to ensure the required nurse staff posting information was posted daily. This had the potential to affect all 94 residents residing in the facility. Findings include: On 6/27/2021, at 12:55 p.m. the nurse staff posting titled Direct Staff Working Hours which was posted in the main entrance area lacked the current date and the facility census. The Direct Staff Working Hours postings 5/22/21, through 6/26/21, were reviewed. Only 3 days (5/22/21, 6/7/21, and 6/10/21) were posted for this time period. In addition, the 3 days which had	F 732	F 732 The daily nurse staff information for dates 5/22/21 through 7/1/2021 was updated during the facility survey and revised to reflect current facility staffing information and census. The staffing coordinator and licensed nurses will be in-serviced on the staffing policy and procedure with focus on #1: within 2 hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personal directly responsible for resident care will be posted in a prominent location and in clear and readable format. Related to timeframe of posting and #3: staffing information shall be recorded on the		

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F 732	Continued From page 21 been posted all lacked the facility census. On 6/28/21, at 8:49 a.m. the scheduling coordinator (SC)-A was interviewed and stated she was responsible for completing and posting the nurse staff posting information. SC-A stated she had not been posting them consistently, nor was she consistently including the facility census information. SC-A stated she completed the nurse staff posting every morning. SC-A stated she placed them in a binder in her office. On 7/1/21, at 10:41 a.m. administrator stated he would expect the Direct Staff Working Hours posting would be completed daily with the required information, as well as any changes to staffing. The facility policy Posting Direct Care Daily Staffing Numbers dated 7/29/16, directed the facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The policy further directed information on the form included date for which the information is posted, resident census, and actual time worked for each shift.	F 732	nursing staff directly responsible for resident care form for each shift. The information recorded on the form shall include: A. The name of the facility. B. The date for which the information is posted. C. The resident census at the beginning of the shift for which the information is posted. D. 24-hour shift schedule operated by the facility. E. The shift for which the information is posted. F. Type and category of nursing staff working during that shift. G. The actual time worked during that shift for each category and type of nursing staff. H. Total number of licensed and non-licensed nursing staff working for the posted shift. Staffing coordinator and/or designee is responsible for compliance. Audits for staffing posting requirements will begin weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and them brought to QAPI for review and recommendation. Compliance: 7/29/2021		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 20, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: QSAX11

Dear Administrator:

The above facility was surveyed on June 28, 2021 through July 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri 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
Office: (218) 302-6151 Mobile: (218) 766-2720

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,



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 07/01/2021
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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 6/28/21, through 7/1/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT found to be in compliance with the MN State Licensure. The following complaints were found to be	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/23/21

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 07/01/2021
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) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H5227137C (MN74150). Licensing orders were issued at 4658.0085 Subp 1 0800. H5227138C (MN74200). Licensing orders were issued at 4658.0510 Subp 1 0830. H5227139C (MN73319). Licensing orders were issued at 4658.0510 Subp 1 0830. H5227140C (MN71966). Licensing orders were issued at 4658.0510 Subp 1 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule 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 surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient nursing staff to provide and meet the needs for 4 of 6 residents (R4, R6, R9 and R10) reviewed for activities of daily living (ADLs). Findings include:	2 800	R4 received a shower on 7/2/2021, R6 received a shower on 7/2/2021, R9 received a shower on 7/11/21 and R10 received a shower on 7/1/2021. R4, R6, R9 and R10's ADL care plan for showers were reviewed and bathing preferences were updated as needed. All other	7/29/21

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2 800	Continued From page 3 R4's Admission Record printed 7/1/21, indicated R4's diagnoses right sided paralysis and weakness related to stroke, morbid obesity, and depression. R4's quarterly Minimum Data Set (MDS) dated 6/12/21 indicated R4 was cognitively intact, required extensive assistance with activities of daily living (ADLs) including bathing, toileting and transfers using a mechanical lift. R4's MDS also indicated no rejection of cares or services. R4's care plan initiated 5/23/2014, indicated R4 was extensive assist to totally dependent on staff for showers. R4's care plan further indicated R4's wishes were to be showered three times per week on afternoon shift. R4's Task Sheet printed on 7/1/21, indicated R4 had only received a shower for the entire month of June, 2021. On 6/12/21, at 10:06 p.m. a progress note indicated R4's weekly vitals and skin assessment had not been completed due to R4 not having a shower. The progress note lacked why R4 did not receive a shower. On 6/19/21, at 2:30 p.m. a progress note indicated R4's weekly vials and skin assessment had not been completed due to short staffing. On 6/29/21, at 11:09 a.m. R4 was interviewed and stated she recalled waiting for over a half hour on her commode waiting for staff to return and assist her with toileting. R4 stated she had sat there so long her legs felt weak and she could barely stand after sitting on the commode for that amount of time. R4 stated the facility did not	2 800	resident's desire for bathing preferences were reviewed and updated as needed. Future resident bathing preferences will be obtained upon admission. Nursing staff will be in-serviced on the Shower/Tub Bath Policy and procedure with focus on all items under documentation and reporting. Nurse aides will be responsible for reporting refusals to the assigned nurse and alternative interventions will be explored by IDT team. The facility leadership along with the corporate recruitment team have and continue to diligently seek talent to support and retain staff at the facility. Our efforts include referral, retention and shift bonuses, flexible schedules, higher hourly rates for licensed RNs, and staff appreciation days. Our plan is to expand our nursing staff as candidates apply and are trained. The Director of Nursing and/or designee is responsible for compliance. Audits on resident bath acceptance and bathing refusal documentation will begin 2x week for 2 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/29/2021	

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2 800	Continued From page 4 have enough staff, and there were times there had only been one nursing assistant for all residents on her unit. R4 further stated she was scheduled to receive showers three times weekly, but had not been getting them. R6's Admission Record printed 7/1/21, indicated R6's diagnoses included weakness and need for assistance with personal cares. R6's quarterly MDS dated 5/4/21, indicated R6 was cognitively intact, and required extensive assistance with ADLs including bathing, toileting and with transfers using a mechanical lift. R6's MDS also indicated no rejection of cares or services. R6's care plan dated 2/4/21, indicated R6 required assistance from 1 to 2 staff for transfers with mechanical lift and limited assistance of one staff for bathing/showering. The facility Weekly Shower Schedule dated 6/11/21, indicated R6 was to have showers on Sundays and Wednesdays on the afternoons (PM) shift. R6's Task Sheet printed on 7/1/21, indicated R6 had not received a shower for the entire month of June, 2021. On 6/2/21, at 10:09 p.m. a progress note indicated R6's weekly vials and skin assessment had not been completed due to no shower because of short staffing. On 6/23/21, at 10:16 p.m. a progress note indicated R6's weekly vials and skin assessment had not been completed due to not being given a shower. The progress note lacked indication of	2 800		

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2 800	Continued From page 5 why R6 was not given a shower. On 6/30/21, at 8:21 a.m. R6 was interviewed and stated the facility had been short staffed. R6 stated she had not been receiving her scheduled showers due to the facility being short staffed. R6 further stated it took two staff to get her up out of bed, and she could wait for over an hour for staff to come and get her up. R9's Admission Record printed 7/1/21, indicated R9's diagnoses multiple sclerosis (disease that damages the cells in the brain and spinal cord) and muscle weakness. R9's quarterly MDS dated 6/5/21, indicated R9 was cognitively intact and was dependent on staff for assistance with ADLs including bathing, toileting and transfers using a mechanical lift. R6's MDS also indicated no rejection of cares or services. R9's care plan dated 10/11/2018, indicated R9 required one staff assist and a mechanical lift to transfer to the shower chair, and one staff to participate with bathing. R9's care plan further indicated R9's wishes were to be showered three times per week on day shift. The facility Weekly Shower Schedule dated 6/11/21, indicated R9 was to have showers on Sundays, Wednesdays, and Friday on day shift. R9's Task Sheet printed on 7/1/21, indicated R9 had received a shower on 6/9/21, and no other times in June, 2021. On 6/4/21, at 1:00 p.m. a progress note indicated R9's weekly vials and skin assessment had not been completed due to no shower because of	2 800		

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2 800	Continued From page 6 short staffing. On 6/18/21, at 2:11 p.m. a progress note indicated R9's weekly vials and skin assessment had not been completed due to no shower because of short staffing. On 6/30/21, at 8:11 a.m. R9 was interviewed and stated she was not getting a shower like she should. R9 stated it had been a while since the staff had been giving her scheduled showers. R9 stated the evening before, there had only been two staff working, and that was not enough to help all the residents on the unit. R9 stated she had also waited a long time for staff to answer her call light. R10's Admission Record printed 7/1/21, indicated R10's diagnoses quadriplegia (paralysis of all four limbs), muscle weakness and pressure ulcer to right and left buttocks. R10's quarterly MDS dated 5/31/21, indicated R10 was cognitively intact, and required extensive assistance from staff with ADLs including bathing, toileting, and transfers using a mechanical lift. R10's MDS also indicated no rejection of cares or services. R10's care plan dated 11/19/2018, indicated R10 required one staff assist and a mechanical lift to transfer to his personal shower chair and one staff to participate with bathing. R9's care plan further indicated R9's wishes were to be showered three times per week on day shift. The facility Weekly Shower Schedule last undated 6/11/21, indicated R10 was to have showers on Mondays, Thursdays, and Saturdays on evening shift.	2 800		

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2 800	Continued From page 7 R10's Task Sheet printed on 7/1/21, indicated R10 had received a shower on 6/3/21, and no other times the month of June, 2021. On 6/12/21, at 10:01 p.m. a progress note indicated R10's weekly vials and skin assessment had not been completed due to R10 not receiving a shower. The progress note lacked indication of why R10 had not received a shower. On 6/30/21, at 8:18 a.m. R10 was interviewed and stated he had not been getting his scheduled showers for weeks at a time. R10 further stated there were "big problems" with staffing, and long call light wait times. On 6/29/21, at 3:38 p.m. nursing assistant (NA)-A stated there had been times there had been only one NA per unit at the facility. NA-A stated the facility management was aware of the short staffing, but nothing had changed. NA-A stated even at times with two staff working there was not enough help to provide the cares the residents needed. On 6/30/21, at 7:33 a.m. NA-F stated it was impossible to get everything completed such as answering call lights, toileting, and giving showers. NA-F further stated other staff have voiced the same concerns about not being able to provide resident care but nothing was done. On 6/30/21, at 1:25 p.m. NA-B stated she had worked a 16 hour day on 6/29/21. NA-D stated she had been the only NA working in the facility from 10:00 p.m. until 12:00 midnight. NA-D stated the licensed nurses do try to help the NAs, but all cares still had not been able to be provided to the residents. NA-D stated showers were not	2 800		

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2 800	Continued From page 8 able to be given due to current staffing. NA-D stated they try to get repositioning and toileting completed timely, but were not able to do it. On 6/30/21, at 11:35 a.m. the administrator was interviewed. The administrator stated he felt staff were able to give the residents the care they required such as showers, but felt the concern was staff were not documenting when they provided the cares. On 7/1/21, at 8:17 a.m. the both the director of nursing (DON) and administrator were interviewed. The administrator stated the facility had been continuing to take admissions even though there had been staffing issues. The administrator stated the facility had been working on the staffing problem. The administrator stated he had been aware of residents missing showers some day,s but the residents who were vocal about not getting showers were getting them. The administrator stated if residents and staff were verbalizing concern that showers were not being completed, that would be a staffing concern. The facility policy Facility Assessment undated, directed the facility will conduct, document, and annually review a facility wide assessment, which included both their resident population and the resources the facility needs to care for the residents. The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations as well as emergencies and to provide person centered care and services required. SUGGESTED METHOD OF CORRECTION: The facility administrator or director of nursing (DON) could review and revise policies and staffing schedules to assure adequate staff are available	2 800		

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2 800	Continued From page 9 to assist residents in a timely manner and to meet all resident needs. The facility administrator or DON could monitor the system to assure cares are being delivered and residents are supported to achieve and maintain their highest practicable physical, mental, and psychosocial well-being. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the health care power of attorney (POA) and the primary care provider (PCP) of refusals of dialysis, medications, and paracentesis for 1 of 3 residents (R1) reviewed for dialysis. This resulted in an immediate jeopardy (IJ) when R1 refused dialysis, medications, and paracentesis, and the facility did not notify the health care POA or the physician, and R1	2 830	F 698 R 1 was transferred out of facility on 6/7/21 to acute care hospital where she died on 6/9/21. Current residents receiving dialysis services charting was reviewed from 5/28/2021 □ 7/22/21 and there were no refusals to go to dialysis on their scheduled days. Future resident admissions who require dialysis and	7/29/21

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2 830	Continued From page 10 subsequently died. The IJ began on 5/28/21, when R1 began refusals of dialysis, medications, and paracentesis. The administrator and director of nursing (DON) were notified of the IJ on 6/30/21, at 4:18 p.m. The IJ was removed on 7/1/21, at 2:08 p.m. but non-compliance remained at the lower scope and severity of a D, potential for more than minimal harm. Findings Include: R1's Admission Record printed 7/1/21, indicated R1 was admitted to the facility on 5/27/21, with diagnosis that included cirrhosis of liver (liver damage leading to scarring and liver failure), end stage kidney disease, septicemia (infection in the blood stream), spontaneous bacterial peritonitis (infection of the inner abdominal wall), hepatic encephalopathy (loss of brain function when a damaged liver doesn't remove toxins from the blood) and chronic pancreatitis (inflammation of the pancreas). R1's admission Minimum Data Set (MDS) dated 6/1/21, indicated R1 had no cognitive impairment, had complex medical conditions, required dialysis (acts as the kidneys, filtering and purifying the blood using a machine), required paracentesis (procedure in which fluid is removed from the abdominal cavity), and required extensive assistance with activities of daily living (ADLs). R1's MDS also indicated she had rejection of care 1-3 days in the past 7 days. R1's baseline care plan initiated 6/2/21, lacked indication R1 received dialysis and had daily paracentesis. The care plan also lacked interventions for rejection of treatments and	2 830	refuse services, the MD, family representative and dialysis company will be notified. Nursing staff were education on 6/30/2021 and again on 7/2/2021 on the Refusal of Treatment policy, the resident response and reason/reasons for refusal, notification to the resident representative and documentation reflected in the resident electronic medical record. Director of Nursing and/or designee is responsible for compliance. Audits on refusal of care and MD and resident representative notification will begin 3x week x 2 weeks, 2x week for 4 weeks, weekly x 4 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 7/29/2021	

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2 830	Continued From page 11 medications. R1's Physician Orders dated 5/27/21, included an order for dialysis on Monday, Wednesday, and Friday, PleurX abdominal drain (for paracentesis) to be drained one time daily at 8:00 p.m., Cipro (antibiotic) 250 milligram (mg) po (by mouth) one time daily, Lactulose (encephalopathy treatment) 20 grams (gr) per 30 milliliters (mls) 20 gr by mouth one time daily, Creon (pancreatitis medication) capsule 24000-76000 units 2 capsules by mouth three times a day, Renal Capsule (vitamin) 1 mg once daily, and Midodrene (to treat low blood pressure) 10 mg by mouth three times daily. On 6/29/21, at 8:39 a.m. R1's family member (FM)-A was interviewed and stated she had faxed the facility the paperwork which indicated FM-A was R1's POA for health care. FM-A stated R1 had been receiving dialysis prior to being admitted to the nursing home, and she also required paracentesis. FM-A stated R1 had never refused dialysis treatments while in the hospital prior to her nursing home stay. FM-A stated R1 had told her she wanted to continue the dialysis to extend her life, to see her grandchildren grow up. FM-A stated she had told the facility if R1 became confused, it was a change in condition for her. FM-A stated the facility had not notified her of R1's refusals of dialysis, medications, or paracentesis. FM-A stated had she been notified, she would have gone to see R1 to make sure this was what R1 wanted. On 6/4/21, a progress note indicated R1 refused to go to dialysis. The progress note lacked indication if R1's primary care provider (PCP) or FM-A were notified.	2 830			

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2 830	Continued From page 12 R1's medical record lacked any further documentation of when she did not attend dialysis. The dialysis center provided the following information: On 6/2/21, an Absence and Hospitalization Record indicated R1 did not receive dialysis that day. On 6/4/21, an Absence and Hospitalization Record indicated R1 did not receive dialysis that day. On 6/7/21, an Absence and Hospitalization Record indicated R1 did not receive dialysis that day. Review of R1's June 2021, and July 2021 Medication Administration Record (MAR) indicated the following: PleurX abdominal drain (paracentesis) had been refused on 5/28/21, 5/30/21, 5/31/21, 6/3/21, and 6/5/21. Cipro 250 mg po daily had been refused on 5/27/21, 5/28/21, 5/29/21, and 6/3/21. Lactulose 20 gr per 30 mls, 20 gr once daily had been refused on 5/28/21, 5/31/21, 6/3/21, 6/5/21, 6/6/21 and 6/7/21. Creon capsule 24000-76000 units ordered for 2 capsules 3 times a day had been refused on 5/28/21, 2 doses; 5/29/21, 1 dose; 5/30/21, 2 doses; 6/2/21, 2 doses; 6/3/21, 2 doses; 6/4/21, 2 doses 6/5/21, 3 doses; 6/6/21, 1 dose; and 6/7/21, 1 dose. Renal Capsule 1 mg once daily had been refused	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From page 13 on 5/28/21, 5/29/21, 5/30, and all days from 6/2/21, through 6/6/21. Midodrene 10 mg three times a day had been refused on 5/28/21, 2 doses; 5/29/21, through 6/4/21, 1 dose each day; 6/5/21, 2 doses; 6/6/21, 1 dose; and 6/7/21, 2 doses. R1's medical record lacked documentation if FM-A or R1's PCP were notified of R1's refusal of medications. A Physician Visit Report dated 6/3/21, written by nurse practitioner (NP)-A indicated R1 allowed the PleurX drain to be drained today. The report further indicated R1 was tolerating medications. The report lacked indication of R1's refusal of dialysis or refusal of medications. On 5/27/21, at 9:43 p.m. a progress note indicated FM-A had called to check on R1, and stated that she was R1's POA for health care decisions. FM-A stated she would be faxing the paperwork in the morning. On 5/29/21, at 5:18 p.m. a progress note indicated R1 refused to let the nurse look at her drain. R1 stated, "It is just fine." The progress note lacked indication if FM-A or R1's PCP were notified of R1's refusal. On 5/29/21, at 6:33 p.m. a progress note indicated R1 had been refusing "just about everything." R1 would not let the nurse look at her PleurX drain. R1 stated it was "just fine" and did not need to be emptied. R1 was also refusing most of her pills and meals. The note indicated FM-A would be called and updated. The progress note lacked indication if R1's PCP was notified, and lacked indication if FM-A had been called.	2 830			

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2 830	Continued From page 14 On 6/1/21, at 4:16 p.m. a progress note indicated R1 had been refusing some of her medications, and had been refusing the PleurX drainage over the last three days. The note indicated the refusals were discussed with R1. R1 had been having some difficulty breathing due to the increase of abdominal fluid buildup. The note indicated the physician would be notified, but lacked indication if he/she was. The note also lacked indication if FM-A was notified. On 6/3/21, at 9:19 p.m. a progress note indicated R1 stated, "It (paracentesis) was drained yesterday and does not need to be done today." The progress note lacked indication if R1's PCP or FM-A were notified of R1's refusal. On 6/7/21, at 3:59 a.m. a progress note indicated R1 was yelling, "Help me" holding onto her abdomen. R1 reported severe pain in her abdomen. Used PleurX drainage system to remove 1100 ml of fluid. Administered as needed (PRN) Oxycodone (narcotic pain medication) 10 mg with effective results. On 6/7/21, at 1:35 p.m. a progress note indicated staff had entered R1's room at 12:15 p.m. to deliver lunch. R1 was lethargic, weak, pale in appearance and dusky in color. R1's respirations were shallow, and her abdomen was distended due to fluid overload. R1 refused dialysis on Friday 6/4/21, and again today. R1 had also been refusing many of her medications and her PleurX. R1 was requesting to go to the hospital. R1 had a full code resuscitation status. FM-A and R1's physician were notified, and R1 was sent to the emergency department (ED) via ambulance. On 6/7/21, an ED note indicated R1 apparently	2 830		

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2 830	Continued From page 15 voluntarily skipped dialysis last week. R1 was noted to be hypotensive (low blood pressure) in the nursing home and was sent to the ED for evaluation. The note further indicated upon arrival to the ED, R1's blood pressure was very low, R1 was listless, and minimally responsive. R1's abdomen was slightly distended, and a PleurX catheter was noted in the right abdomen. On 6/9/21, at 6:57 p.m. a progress note indicated the hospital had called and informed the facility R1 had expired at 6:25 p.m. On 6/30/21, at 10:23 a.m. the director of nursing (DON) was interviewed and stated she would have expected FM-A and R1's PCP to have been notified of R1's refusal to go to dialysis, and her refusals of paracentesis and medications. The DON verified staff did not consistently document R1's refusals of dialysis, paracentesis or medications, and she would expect them to. On 6/30/21, at 2:55 p.m. NP-A was interviewed and stated he had only seen R1 as a patient one time on 6/3/21. NP-A stated the facility had reached out to him on 6/2/21, with concerns related to R1's refusal of the paracentesis. NP-A stated if a resident refused cares or treatments, he would expect to be notified. The facility policy Dialysis Care dated 2/12/20, directed any significant change in the resident's status related to clinical complications or emergent situations, the nursing home staff will communicate with and notify the attending physician/practitioner, resident/resident representative and dialysis staff. This notification will be documented in the resident's electronic medical record. Refusal of treatment, missed appointments, canceling or postponing treatment,	2 830		

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2 830	Continued From page 16 the nursing home staff will contact the dialysis and will begin daily observation and medical management until dialysis is rescheduled/resumed. The facility policy Refusal of Treatment updated 6/30/21, directed "Treatment" is defined as a care provided for purposes of maintaining/restoring health, improving health, improving function level, or relieving symptoms. The policy directed staff if a resident refuses treatment, the unit manager, Charge Nurse, or Director of Nursing Services will interview the resident to determine what and why the resident is refusing in order to address the residents concern and explain the consequences of the refusal. If a resident's refusal brings about a significant change, a reassessment will be made, and such information will be incorporated into the resident's care plan. The policy further directed staff that documentation of the refusal of treatment include that the resident was informed of the purpose of the treatment and the consequences of not receiving the medication/or treatment as well as the date and time the physician and resident representative was notified as well as the physician's response to the refusal. The immediate jeopardy that began on 5/27/21, was removed on 7/1/21, at 2:08 p.m. when the facility completed an audit of all resident records to ensure physicians and if applicable residents designated representative had been notified of all recent refusals of dialysis, physician ordered treatments and medications. In addition, all licensed staff members were re-educated on what steps to take if residents had a refusal of dialysis, physician ordered treatments and or medications. These actions were verified through interview and record review.	2 830			

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2 830	Continued From page 17 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies to ensure physicians and if applicable residents designated representative are notified for refusals of physician ordered treatments and medications. The DON or designee could educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			