

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 04/20/2024
NAME OF PROVIDER OR SUPPLIER Bayshore Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 St Louis Avenue Duluth, MN 55802	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47790</p> <p>Based on interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) who was at risk for elopement. This resulted in an immediate jeopardy (IJ) for R1 when he eloped from the facility, was not identified as missing for 1.25 hours and found 2 miles away from the facility.</p> <p>The IJ began on 4/15/24 at 6:37 a.m. when nursing assistant (NA)-A saw R1 outside of the facility on the sidewalk in front of the building, mistook him for a visitor, and cleared the wanderguard door alarm without searching for a missing resident. The administrator and director of nursing (DON) were informed of the IJ on 4/18/24 at 4:30 p.m. The facility had implemented corrective action on 4/16/24, prior to the start of the survey and was therefore Past Noncompliance.</p> <p>Findings include:</p> <p>R1's Face Sheet undated indicated R1 had diagnoses of bipolar disorder and metabolic encephalopathy.</p> <p>R1's Elopement Risk Evaluation dated 4/10/24, indicated R1 had a history of exit seeking and attempting to leave the building which put him at risk for elopement.</p> <p>R1's Brief Interview for Mental Status (BIMS) dated 4/16/24, indicated R1 had moderate cognitive impairment.</p> <p>R1's Medication Administration Record dated 4/18/24, indicated R1 had a wanderguard on his right wrist from 4/11/24 at 10:00 p.m. to 4/15/25 at 9:48 a.m.</p> <p>R1's care plan dated 4/20/24, indicated R1 was at high risk for elopement and wandering.</p> <p>R1's progress note dated 4/15/24 at 9:49 a.m., indicated at around 8:00 a.m. staff where unable to locate R1. R1's guardian and management were notified, and a code 99 (missing resident) was called. The facility staff were unable to locate R1 and the police where called. Administrator reviewed cameras and saw R1 walking out the front doors of the building at 6:37 a.m. Family (F)-A received a call from R1 stated he needed a ride from the Government Building, two miles away, to request a ride back to the facility after checking his food stamp balance. R1's F-A returned R1 to the facility at 9:37 a.m.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/18/24 at 10:43 a.m., nursing assistant (NA)-A stated on 4/15/24 she was walking into the building around 6:30 a.m. and heard the Wanderguard alarm going off. She stated she saw a man outside that looked like a visitor. She had never seen him before but did not see anyone else. She asked the maintenance man to turn off the alarm. It was not until the code for a missing person (code 99) was called which included a description of what the missing resident was wearing. She realized it was the man (R1) she mistakenly thought was a visitor she had seen outside when she was walking into the building.</p> <p>On 4/18/24 at 11:04 a.m., maintenance worker (MW)-A stated on 4/15/24 at around 6:30 a.m., the Wanderguard alarm was going off. NA-A told him the man outside was going to smoke and he did it all weekend, and to turn off the alarm. MW-A stated he had never seen the man outside before. So he turned off the alarm.</p> <p>On 4/18/24 at 12:27 p.m., registered nurse (RN)-A stated she was unable to locate R1 on 4/15/24 and she did not hear an alarm going off that she could recall. RN-A updated the nurse manager on not being able to find R1.</p> <p>On 4/18/24 at 12:47 p.m., RN-B stated on 4/15/24, RN-A came to her at around 7:45 a.m. and stated she could not find R1. RN-B called a code 99 and started looking for R1 (approximately 1.25 hours after R1 was last seen outside) . While talking to staff she found out NA-A heard the alarm going off when she arrived to work and had MW-A assist her with turning off the alarm but they did not look to see if anyone was missing.</p> <p>On 4/18/24 at 1:02 p.m., the director of nursing (DON) stated on 4/15/24 RN-A and RN-B where the ones who came and told her R1 was missing. When the Wanderguard alarm was going off, she would expect staff to find the resident, and if they couldn't, they were to check to make sure everyone is in house.</p> <p>On 4/18/24 at 1:29 p.m., the administrator stated if the alarms go off at any door, staff should go to the alarm and find the person. If they were unable to find anyone, they should do a house sweep to make sure everyone is in house.</p> <p>The facility Elopement Policy reviewed 4/16/24 directed if an employee discovers an alarm going off without a resident present, he/she should: Search the immediate vicinity inside and outside the building for a resident with a wanderguard. If no resident is found, notify charge nurse and director of nursing services and ensure all residents with wanderguard are accounted for.</p> <p>The past noncompliance immediate jeopardy began on 4/15/24. The immediate jeopardy was removed, and the deficient practice was corrected by 4/16/24, after the facility implemented a systemic plan that included the following actions: Elopement policy and process education for all staff, audits being completed to ensure staff understand Elopement Policy and process 3 times weekly for one week then 1 time weekly for a month and then they will review in QAPI. R1 is currently located in a secured unit. Verification of corrective action was confirmed by observation, interview, and document review on 4/18/24.</p>		