

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 12/04/2025
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure residents right to leave the facility was honored for 2 for 3 residents (R1, R2) reviewed who had physicians orders restricting their rights to a leave of absence. R1's admission Record indicated she admitted to the facility on [DATE]. Diagnoses include type 2 diabetes mellites (DMII), infection of left hip, pain, weakness and gait abnormalities.R1's care plan dated 2/10/24, indicated she was at low risk for elopement. The care plan identified substance abuse/dependence as evidenced by resident having alcohol and drug paraphernalia/admitting to substance use and indicated leave of absence (LOA) privileges revoked per physician.R1's Physician Order Report dated 10/20/25, identified the following order dated 7/10/25: Revoked privileges of LOA. Resident not allowed to leave facility per provider.R2's admission Record indicated he admitted to the facility 2/13/25. Diagnoses included: depression, head laceration, anemia, tobacco use and alcohol dependence.R2's care plan dated 9/4/25, indicated R2 had a history of impaired decision making related to choices that put his health and safety at risk despite education and a risk for self-harm related to chemical dependency. The care plan further indicated LOA privileges revoked per provider.R2's Order Summary Report dated 9/2/25, identified the following order dated 8/7/25, indicated LOA suspended due to patient safety concerns. A written agreement between R2 and the administrator dated 8/26/25, indicated R2 agrees to go to the bank and a couple of stores today. R2 promised he would not consume beer or alcohol of any kind while on his shopping trip today. R2 would be home by 5:00 p.m. This will be a one-time trip and will be reported to his physician.A written agreement between R2 and the administrator dated 8/29/25, indicated R2 agrees to go to the bank and a couple of stores today. R2 promised he would not consume beer or alcohol of any kind while on his shopping trip today. R2 would leave facility after 9:00 a.m. and return before 2:00 p.m. This will be a one-time trip and will be reported to his physician.During interview on 10/23/25 at 2:01 p.m., social services designee (SSD)-A stated R1's LOA privileges were revoked because she was using drugs and alcohol. SSD-A said typically residents were allowed to leave the facility with family or friends and said the facility asked for information about leaving and returning. During interview on 10/23/25 at 2:07 p.m., the administrator stated R1 had an order from the physician to rescind her LOA status. The administrator stated the facility safety policy trumped the resident's rights. The administrator stated he suspected R1 had been bringing drugs and alcohol into the facility. The administrator said R2 had been doing unsafe things and was warned he would need to discontinue his behavior. After many violations, R2 had his LOA privileges revoked. The administrator said R2 had been allowed to walk around the facility grounds and the building. The administrator said R2 did well and had been set up with some trial leaves and then at one point he did not return to the facility and showed up at the hospital.During interview on 10/23/25 at 3:02 p.m., licensed social worker (LSW)-A stated R1 had gone on leaves from the facility and had not returned on time. LSW-A said they suspected R2 had been under the influence. LSW-S said the physician ordered urinalysis but R1 refused so the physician wrote an order that she could not leave the facility. LSW-A was asked if any less restrictive options were discussed prior to restricting R1's right to leave the facility and said she was not aware of any and had not been directly involved. LSW-A said according to facility policy, leaving the facility was a privilege, not a right and the privilege could be revoked.Facility policy Resident Leave of Absence/Pass privileges dated 5/10/22, indicated the facility recognizes the right of the residents for whom reside at this facility that it is their home and they can choose to leave the facility for limited periods for therapeutic reasons. The facility also recognizes the need of the residents to leave to prepare for discharge. It is not in the best interest of the residents to leave the facility, but it is encouraged to enjoy the facility grounds between times during the provision of medical care. Because the purpose of admission is to provide a continuum of care and treatment, the facility leave of absence policy may be granted in accordance with specific guidelines.Purpose:To clarify circumstances under which authorization for leaving the facility is needed.To establish guidelines regarding the right to return to the facility upon termination of an unauthorized pass.Procedure1. Upon admission, resident wanting to leave the facility during the assessment period will onlybe allowed to leave with a responsible party. Demographic information, including purpose,will be required. The order will read, Resident Ok for pass privileges with responsible party.This order will automatically generate upon the resident arrival/admission to the facility.2. Until the resident is fully assessed by both occupational therapy and the attending physician the physician will deem that the resident is safe to</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</p>

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure appropriate discharge rights for 1 of 3 residents (R1) who was discharged from the facility following a leave of absence. R1's admission Record indicated she admitted to the facility on [DATE]. Diagnosis include DMII, infection of left hip, pain, weakness and gait abnormalities.R1's care plan dated 2/10/24 indicated she was at low risk for elopement. The care plan identified substance abuse/dependence as evidenced by resident having alcohol and drug paraphernalia/admitting to substance use and indicated leave of absence (LOA) privileges revoked per physician.R1's Physician Order Report dated 10/20/25, identified the following order dated 7/10/25: Revoked privileges of LOA. Resident not allowed to leave facility per provider.R1's Resident Discharge Summary indicated she discharged from the facility 10/20/25. the summary identified R1's discharge location as other and indicated, unable to meet her needs.R1's Progress Notes indicated the following:10/20/25 at 5:33 p.m., R1 left the faciity on an LOA, against medical advice (AMA), despite having LOA privileges revoked per physician order. R1 departed the facility with her family. Both R1 and her family were aware privileges had been revoked. Per facility policy and physicians order, leaving the facility under these circumstances was considered leaving AMA. R1 later contacted the facility by phone and was informed she violated the revoked LOA order and was officially considered to have left AMA. R1 was advised she could come back to the facility and collect her belongings.10/20/25. 6:18 p.m., R1 and family member came to the facility to grab R1's coat, writer and nurse went to the car to have R1 sign AMA form. R1 refused to sign the form, arguing the facility was stealing her wheelchair which belonged to the facility. R1 educated if she refused to sign the form, staff would sign with a witness. Writer went to get signature from R1's daughter and R1 repeatedly told her daughter not to sign the form. Daughter said she would sign the form the next morning when they came to get the rest of R1's belongings. AMA form was signed by writer and nurse. 10/21/25, 9:47 a.m., Writer asked R1's daughter to sign AMA paperwork as she stated she would the previous night. Daughter stated she was not signing anything.During interview on 10/23/25 at 1:40 p.m., registered nurse (RN)-A stated she believed R1 was currently with her daughter. RN-A said R1 had previously had her LOA privileges revoked because she had tested positive for drugs and brought alcohol back to the facility. RN-A stated R1 had gone out the previous month and had been re-educated. RN-A said the previous Monday, R1 left the facility without telling staff and the administrator told staff to proceed with the AMA due to not following the physician order and said when R1 called she told her since she broke the policy, she was considered discharged AMA and family could pack her belongings. RN-A said R1 had every intention of coming back to the facility but the administrator said she could not. During interview on 10/23/25 at 2:01 p.m., social services designee (SSD)-A stated R1's LOA privileges were revoked because she was using drugs and alcohol. SSD-A said typically residents were allowed to leave the facility with family or friends and said the facility asked for information about leaving and returning. During interview on 10/23/25 at 2:07 p.m., the administrator stated R1 had an order from the physician to rescind her LOA status. The administrator stated he suspected R1 had been bringing drugs and alcohol into the facility and providing them to other residents. The administrator said there were many discussions with the physicians about why R1 could not leave the facility and indicated the decision was for R1's safety. The administrator said RN-A had reported to him, R1 had left the facility and he told RN-A to follow the AMA procedure.During interview on 10/23/25 at 3:49 p.m., the director of nursing (DON) stated the facility did not have any evidence R1 was giving drugs or alcohol to other residents, only suspicion.During interview on 10/23/25 at 3:02 p.m., licensed social worker (LSW)-A stated R1 had gone on leaves from the facility and had not returned on time. LSW-A said they suspected R1 had been under the influence. LSW-S said the physician ordered urinalysis but R1 refused so the physician wrote an order that she could not leave the facility. During interview on 10/23/25 at 4:53 p.m., the administrator stated R1 did well when she was sober and family was able to visit and he felt it was healthier for R1 to remain at the facility and not go on LOA.Facility policy Transfer or Discharge Notice dated 7/22/16, indicated:Except as specified below, a resident, and/or his or her representative (sponsor) will be given a thirty (30)-day advance notice of an impending transfer or discharge from our facility and a bed hold notice given to the resident and/or representative for emergent transfers or therapeutic leave:a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility.b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer</p>		