STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. Building B. Wing	04/17/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview, and documents review the facility failed to remove medications after each use for a resident not approved to keep at bedside. This affected 1 of 1 resident (R33) reviewed for self-administration of medication. Findings include: R33's significant change Minimum Data Set (MDS) dated [DATE], identified R33 had intact cognition. Diagnosis included dementia and Parkinson's disease. R33's Self Administration of Medication (SAM) assessment dated [DATE], identified R33 could not identify expiration date of each medication and to continue plan of care. R33's SAM assessment dated [DATE], identified R33 could not identify expiration date of each medication and to continue plan of care. The SAM also identified either R33 did not want to self-administer medications or was unable to determine. R33's care plan undated, lacked documentation related to R33's SAM assessment. During observation on 4/14/25, at 2:16 p.m., a bottle of nystatin powder with R33's name on it was noted on the bedside table in R33's room. During a second observation on 4/16/25 at 7:43 a.m., a bottle of nystatin powder with R33's name on it was again observed on the bedside table in R33's room. During an interview on 4/16/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated to keep medications at the bedside there needs to be a SAM assessment completed that showed the resident was safe to self-administer medication and to keep the medication at bedside. There also needs to be a provider order to keep the medication at bedside. LPN-A entered R33's room and confirmed a bottle of nystatin powder was on R33's bedside table. LPN-A stated R33 did not have a SAM that okayed medications to be kept at bedside because R33 could not self-administer. During an interview on 4/17/25, at 12:31 p.m. registered nurse (RN)-A stated the SAM assessment indicating the resident is cleared to self -administer medication and a provider order needed to be in place before a resident could self-administer medications or keep medications at bedside. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/25 at 12: 38 p.m., the director of nursing (DON) stated the SAM assessment and provider order need to be in place to store medications at bedside. Facility policy Self-Administration of Medication last reviewed 12/13/21, indicated if the facility determined a resident was not safe to self-administer medications, the nursing staff would administer the medications. The policy did not discuss if it was safe to store medications at bedside if the resident could not safely self-administer medications.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and record review, the facility failed to maintain respect and dignity for personal space for 2 of 3 resident's (R31, R55) reviewed who had their room searched without consent. Findings include: R31's clinical admission undated, indicated R31 was her own responsible party. R31's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R31 had intact cognition. Diagnoses included heart failure, anxiety and depression. R31's care plan last updated 5/31/24, indicated resident had a behavior problem related to false accusations and blaming others of mistreatment. One documented trigger for behavior listed under interventions was room searches. R31's active order list dated 7/29/24, indicated search room in pairs after each leave of absence, family visit, and as needed. Review of R31's progress notes from 11/1/24 to 4/16/25 indicated the following: - 4/14/25 at 5:54 p.m., writer did a room search with social services and administrator after visitor left. Resident refused search of person and purse. After much discussion regarding choices that have led up to current life choices resident let staff search purse. - 4/10/25 at 5:03 p.m., resident had visitor. Room search completed. Resident allowed but stated: this is a violation of my rights. - 4/8/25 at 10:33 a.m., a Situation, Background, Assessment and Recommendation (SBAR) report was sent to provider that indicated a room search was completed and items found. Recommendations included to restrict leave of absence rights and revoke rights to leave the facility and was signed by the provider. - 4/7/25 at 10:01 p.m., resident son and another visitor came. Resident and visitors went outside at 9:45 and room search was completed. - 4/7/25 at 3:50 p.m. a routine room search was conducted in accordance with facility policy. - 1/2/25 at 9:54 p.m., room search completed as ordered. - 12/5/24 at 9:44 p.m. room search completed. - 11/30/24 at 3:25 p.m. the resident's room was searched this afternoon. (the medical record indicated the resident had been hospitalized from 11/28/24 to 12/3/24). (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/25 at 2:07 p.m., R31 stated the facility kept performing searches of her room at all times of the day. They come in two at a time anytime I have a visitor and search my furniture, go through the drawers and purse. Sometimes they even try to search me. They never tell me why; they just walk in and start going through my stuff. Sometimes they ask for permission, but I do not consent to the search. When I don't voluntarily consent to the search they keep talking and pushing until I finally given in and say they can search my stuff. During an interview on 4/16/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated there were residents who had orders to search their rooms after visitors had been present or when the resident left the facility and returned. LPN-A confirmed R31 was one of those residents but LPN-had not done any searches in R31's room. LPN-A believed they did need permission before doing any searches. During an interview on 4/16/25 at 7: 56 a.m., the social services designee (SSD) stated she had participated in room searches of R31's property. All searches were done according to facility policy. R31 did not always give consent voluntarily to perform the search, but after talking with her she would eventually give consent. During an interview on 4/16/25 at 11:58 p.m., registered nurse (RN)-A stated staff did not need permission to perform room searches in R31's room. If we had a concern, our policy allowed us to do the room searches based on those concerns. We would ask R31 for permission, but she did not always give it. During an interview on 4/16/25 at 1:17 p.m., the administrator stated all room searches were done following facility policy. The facility policy Resident Personal Possession Search last reviewed 10/18/22, indicated there would be a reasonable suspicion that a resident had contraband prior to conducting a room/belonging search. Before the search took place, the search must first be approved by the administrator. The items in plain view could be taken by staff. Otherwise, any resident possessions, the resident and/or resident representative must understand why the search was conducted and provided verbal consent before a search of personal items and person was executed. The verbal consent would be documented by the administrator and the provider would be notified by the director of nursing.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 51567 Based on observation, interview and document review, the facility failed to ensure the most recent state agency (SA) survey results were readily accessible and post signage and/or notice of the inspection reports within the campus. This had potential to affect all 87 residents, visitors, and their families who could wish to review the information. Findings include: During an observation and interview on 4/14/25 at 12:35 p.m., no posted signs were available for survey results. The receptionist (O)-H stated that the survey results were kept in a green binder, located to the left of the front desk. The binder was stored on a plastic shelf affixed to the counter and secured with a cable; as a result, survey results were reviewed at the front desk rather than in private. The binder was organized with plastic tabs labeled for the years 2023 and 2022, with the most recent survey results dated June, 2023. During an interview on 4/14/25 at 4:31p.m., O-H stated that the administrator was responsible for maintaining the binder containing the state survey results. During an interview on 4/15/25 at 10:39 a.m., administrator confirmed responsibility for maintaining the binder with the survey results and confirmed the the most recent results available in the binder were from June, 2023. Administrator also confirmed that survey results and complaints from 2024 and 2025 were added to the binder after the survey team entered the building on 4/14/25. All policies related to survey results were requested, no policies were received.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation and interview, the facility failed to ensure a resident's room was clean and homelike for 1 of 3 residents (R45) reviewed for environment. Findings include: R45's admission Minimum Data Set (MDS) dated [DATE], identified an admitted [DATE], and primary diagnosis as orthopedic care following surgical amputation of the right lower leg. During observation and interview on 4/14/25 at 4:02 p.m., R45 stated his room was too dark, there were stains and holes in the walls, one of the blinds wouldn't raise or lower and these things bothered him. On observation, there were several screw holes in the wall between the two windows, and multiple streaks of a brownish-black substance four to five inches long on the wall behind his bed and chair that bothered him. The light over the sink area had droplets of a brown, dried substance on it, and a glob of something brown and thick of about 1 inch long on the front of the light. There was one light over the sink, one over his bed, and one over his chair. R45 stated he has complained to staff about this room. During observation and interview on 4/16/25 at 10:53 a.m., maintenance worker (MW)-B stated they didn't have a routine for checking rooms for maintenance issues because they are in and out of the rooms quite a bit. MW-B said when a room is vacated, they check the lights, doors, toilet, sink, drawers, and closet doors. MW-B stated he was familiar with R45's room and they had painted that room shortly after a resident passed, then R45 was the next resident in the room. MW-B stated R45 had complained about the lighting, so he replaced some bulbs, but he wasn't aware of the holes in the wall and would say that wasn't homelike. As far as the stains on the walls and light fixtures, housekeeping would be responsible for those. During an observation and interview on 4/17/25 at 12:18 p.m., housekeeper (HSK)-A stated every room was house kept daily and included wiping down all surfaces, bathroom, sinks, toilet, sweep and mop the floor. Once a month, or if the resident was out of the building, they will do a deep cleaning of the room. HSK-A stated they didn't have a schedule but just kind of do it on their own. HSK-A observed the stains on R45's walls and light fixture, and acknowledged she could wipe them down, but the lights would have to be maintenance. HSK-A confirmed there was a process for maintenance requests for things that needed to be fixed. During an interview on 4/17/25 at 2:21 p.m., the administrator stated deep room cleaning was done annually and when there was a vacancy. Maintenance had a list of things to go through, including wall repair. The administrator stated he was familiar with R45's room and declined touring it at this time. The administrator's expectation was for resident's rooms to be clean and homelike. A policy, Homelike Environment dated 12/8/21, identified its purpose was for residents to be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The policy didn't address repairs to walls.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 4 residents (R65, R86) reviewed for accuracy of assessments. Findings include: R65: R65's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and a diagnosis of morbid obesity. Section N of the MDS identified R65 received one injection of insulin during the assessment period. R65's provider orders dated 1/10/24, identified Trulicity (an injectable non-insulin medication used to improve blood sugar levels) one time weekly. R65's medication administration record for February 2025 identified Trulicity administration on 2/21/25. During an interview on 4/16/25 at 10:35 a.m., registered nurse (RN)-B confirmed the only injectable medication R65 was taking between 2/17 and 2/24/25 would have been Trulicity. During an interview on 4/17/25 at 10:42 a.m., RN-E confirmed she was the nurse responsible for R65's MDS of 2/24/25. RN-E stated her process was to review the resident's orders and other charting to gather information. RN-E reviewed the medication list from the assessment period and confirmed R65 was using Trulicity and she must have coded it as insulin. RN-E state accurate MDS' were important because they affect case mix. A policy for MDS completion was requested but not received. R86: R86's MDS dated [DATE], indicated R86 was cognitively intact with diagnoses of cancer, atrial fibrillation, and generalized muscle weakness. R86's Care Plan Report last updated on 4/16/25, listed resident performance eating - independent/set-up help only provide verbal cues to swallow as needed and take small bites. Head should be upright/forward not leaning back when drinking liquid. The care plan did not identify R86 had dysphasia and lacked instruction for supervised meals. R86's Order Summary Report Active Orders as of 4/17/25, included the following orders: -regular diet ground meat texture, thin liquids -ensure mouth is clean before and after every meal, per speech therapy recommendations (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-eating: staff supervision, provide verbal cues to swallow as needed, take small bites. head upright/forward when drinking liquids, not leaning back every shift. -Speech eval and treat A Swallow Evaluation Document dated 3/14/25, completed by an Essentia Health Speech therapist indicated R86 had oropharyngeal dysphasia characterized by weakness and decreased coordination. The evaluation recommended cues for head positioning, cues for small bites/sips and follow-up therapy after neurology consult. A nursing note entered on 3/24/25, indicated R86 had had an episode where they could not swallow chicken and had coughed it up on their own. The note referred to speech therapy recommendations and orders in chart for supervision with meals. A provider note dated 3/25/25, included the diagnosis oropharyngeal dysphagia and indicated R86 had been prescribed a new diet order for ground meat post choking episode without overt aspiration. R86's MDS assessment dated [DATE], lacked the following coding: -Section I Active Diagnoses failed to identify R86 had a diagnosis of dysphagia. -Section K Swallowing/Nutrition disorder part K0100 did not identify documented symptoms of possible swallowing disorder that had been identified in R86's medical record. -MDS Section GG - Functional Abilities and Goals failed to identify R86 required supervision with eating. During an interview on 4/17/25 2:07 p.m., RN-E explained when completing the MDS documentation for the seven day look back period gets reviewed. We also meet and review GG during facility IDT meetings. R86 should have been coded for supervision with meals, the risks factors for swallowing should have been coded and the dysphagia diagnosis should have been coded and added to R86's active diagnoses. It is important for these things to be coded correctly so additional changes can be made to update the resident's plan of careplan and the Kardex for staff to follow. The policy Electronic Transmission of the MDS dated [DATE], indicated the MDS coordinator was responsible for all ensuring all appropriate edits were completed prior to the transmission of MDS data.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review, the facility failed to ensure fluid restrictions were monitored for 2 of 2 residents (R5, R31) reviewed for quality of care. In addition, the facility failed to notify the provider upon resident refusal of medication and when a resident's weight went outside prescribed parameters for 1 of 1 resident (R45). Findings include: R5: R5's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R5 had intact cognition. Diagnoses included anemia and end stage renal disease. R5 currently received hemodialysis. R5's care plan dated 11/14/24 indicated a risk for altered fluid balance related to (R/T) kidney disease and heart disease: 1200 milliliter (ml) fluid restriction. R5's provider orders dated 3/15/25 indicated a 1200 ml fluid restriction to be documented on each shift. Review of R5's medical record indicated the following: - On 4/9/25 1580 ml of fluid was received - Fluid intake documentation was missed on 3 shifts, NA was charted on 3 shifts and an X was charted on 3 shifts instead of that shift's fluid intake. R31: R31's significant change MDS assessment dated [DATE], indicated R31 had intact cognition. Diagnoses included anemia, heart failure, and renal insufficiency. R31's care plan last revised on 1/31/25, indicated resident had congestive heart failure with an intervention that included a 64 ounce/day (1920 ml) fluid restriction. R31's orders dated 7/29/24 indicated a 64 ounce/day (1920 ml) fluid restriction to be charted on every shift. Review of R31's treatment records for 1/25-4/25 indicated the following: - During month of 1/25 3 shifts did not document any kind of intake, and 13 shifts documented NA instead of an intake number. - During the month of 2/25 9 shifts did not document any kind of intake, and 6 shifts documented NA instead of an intake number. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- During the month of 3/25 7 shifts did not document any kind of intake, and 5 shifts documented NA instead of an intake number. - During the month of 4/25 4 shifts did not document any kind of intake. During an interview on 4/16/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated dietary would send up a set amount of liquid with each meal. Nursing staff also had a set amount of fluid that could be given outside of mealtime. The nurse assistants kept track of the numbers and gave them to nursing to enter in the computer each shift for a total amount every 24 hours. LPN-A confirmed R5 and R31 were on fluid restrictions of some kind. During an interview on 4/16/25 at 10:59 a.m., registered nurse (RN)-C stated nursing entered the total number of intakes each shift. She confirmed R5 and R33 had shifts that either had no documentation or NA as documentation for the month of 4/25. Keeping track of fluid intake when residents have ordered fluid restrictions was important because of the increased risk of fluid overload for residents with heart failure or on dialysis. During an interview on 4/16/25 at 11:18 a.m., the director of nursing (DON) stated fluid intake should be documented on all shifts. A fluid restriction policy was not provided. 48109 R45: R45's significant change in status Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of atrial fibrillation (an irregular heart rhythm), morbid obesity, chronic kidney disease, hypertension, and chronic obstructive pulmonary disease (COPD, a lung and airway disease which restricts breathing). R45's provider orders dated 3/21/25, identified to weigh R45 every other day in the morning before eating or drinking. Call the Heart Center for weight gain of three pounds overnight accompanied by any symptoms of fluid retention; Weight gain or loss of five pounds or more in a week. An order dated 3/13/25 identified Torsemide (a diuretic used to treat fluid retention) 20 milligrams (mg) one time daily. R45's care plan dated 3/24/25, identified a risk for ineffective peripheral tissue perfusion related to edema (excess fluid). Interventions included evaluating for edema, to educate R45 on the necessity to provide care and treatment due to his history of refusing medications and treatments, to notify provider of new-onset findings, and to provide verbal feedback to resident. R45's electronic medical record (EMR) for April 2025 identified the following weights: -4/10 366.4 -4/12 373 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/14 R45 refused to be weighed. -4/16 380.4 On 4/16/25, R45's medication administration record (MAR) for April 2025, identified R45 refused torsemide from 4/10/25 through 4/16/25. R45's progress notes in the EMR didn't reflect provider notification of weight gain or refusals of medication. During an interview on 4/14/25 at 3:53 p.m., R45 stated he refused the diuretic because it made him go to the bathroom so much, he couldn't control his bladder, so he refused it daily. During an interview on 4/16/25 at 1:40 p.m., licensed practical nurse (LPN)-B confirmed she was the nurse caring for R45 today. LPN-B stated the provider was aware of R45's refusals of torsemide and they normally make a progress note when they update the provider, but sometimes information got put in a provider rounding book which was not part of the EMR. LPN-B stated would call the provider if a resident's weight was up or down five pounds, otherwise they fax the weights to the heart center every couple of months. During an interview on 4/16/25 at 1:55 p.m., registered nurse (RN)-B nurse manager stated she wasn't aware R45 had been missing his diuretic or had weight gain. RN-B stated she would expect the nurse to update the heart center with five pound or more gain or loss. For R45, the risk of having too much fluid would be going into heart failure. During an interview on 4/17/25 at 1:23 p.m., RN-B nurse manager stated she had found an SBAR (acronym for situation, background, assessment, and recommendation) communication on 4/10/25 updating the provider of torsemide not taken that day. The communication wasn't part of the EMR. During an interview on 4/17/25 at 3:54 p.m., the director of nursing (DON) would expect a provider be notified when a resident with weight parameters gained weight and would expect vital signs and an assessment be done when a resident like R45 gains weight, and that the weights were reported to the provider. A policy, Refusal of Treatment dated 6/30/21, identified the facility shall honor a resident's request not to receive medical treatment as prescribed by their physician, as well as care routines outlined on the resident's assessment and plan of care. The policy identified if a resident refused a treatment the unit manager, DON, or charge nurse would interview the resident to determine why they were refusing and to try address the concern. Detailed information about the resident refusal should be documented in the medical record. Documentation must contain the date and time of attempted treatment or medication, what was refused, the resident's response and reason for refusing, the name of the person attempting the treatment or medication, that the resident was informed of the reason for the treatment and possible consequences of not receiving the medication or treatment, date and time physician was notified, and the resident's condition. Notification of physician must be made in a time frame determined by the resident's condition and potential serious consequences of the refusal.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on interview and document review, the facility failed to ensure weekly skin checks were performed for a resident who developed a pressure ulcer in the facility, to ensure the resident care plan included the presence of actual pressure ulcers, with individualized interventions based on assessment to include turning and repositioning frequency, the presence of integrated wound therapies, an actual wound infection, and manufacturer's recommendations for checking inflation of a Roho (specially designed inflatable wheel chair cushion) for 1 of 2 (R21) residents reviewed for pressure ulcer care. Findings include: R21's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of multiple sclerosis (MS), quadriplegia, muscle weakness and unstageable pressure wound to left buttock. The MDS identified R21 had limited range of motion in the upper and lower extremities and needed maximum assistance with bed mobility. The 3/6/25 MDS indicated a risk for pressure sores but no actual pressure sore. R21's provider orders identified: -Weekly skin checks on bath days, with a revision on 3/31/25 to include checking the Roho cushion to make sure it was inflated every Tuesday evening. -On 4/4/25 an order for protein supplement shakes three times per day and sulfamethoxazole-trimethoprim (an antibiotic used to treat infections) for 10 days for wound infection. -On 4/10/25 an order for Dakin's half-strength to left ischial tuberosity (bony prominence under buttock) every day shift, cleanse with wound cleanser, apply Dakin's wet to dry, cover with abdominal pad and tape in place. R21's care plan dated 6/17/24 identified a risk for pressure ulcer development related to diagnoses with interventions to monitor for signs and symptoms of infection, administer pain medication as ordered, pressure reducing custom cushion in wheelchair, pressure reduction mattress, weekly treatment documentation, and a new intervention dated 4/9/25 to check Roho cushion for proper inflation. R21's care plan also identified a risk for infection related to chronic wound dated 4/11/25 with interventions to evaluate for signs and symptoms of infection, and to put enhanced barrier precautions in place. R21's electronic medical record (EMR) identified the following: -3/18/25 Weekly Bath Audit V9 completed, no skin issues noted -3/22/25 progress note: Resident had shower this evening. Staff noted redness on perineal/buttock area. Barrier cream applied and oncoming night shift nurse notified. - 3/25/25 progress note: Skin clean, dry and intact. Nothing unusual. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/30/25 progress note: Resident has wound to left buttock. Dressing had drainage and odor, cleaned with wound cleanser and covered with foam border dressing. -3/31/25 progress note: Tylenol for sore backside with pain rated 7/10 -3/31/25 first picture and measurements of the wound which measured 7.6 centimeters (cm) by 4.2 cm by 2. 4 cm deep. -3/31/25 progress note: Notified that resident has new open area on left buttock. Resident states My ass hurts, it's like someone put a cigarette out on it Writer and Nurse manager assessed area. Unstageable pressure injury to left ischium present measuring 4.3 x 2.5 x 0.1 cm. Wound bed is 100% slough with odor present. Foam border dressing applied. Resident is currently on a foam pressure reducing mattress and a ROHO cushion in his wheelchair. ROHO was noted to be flat, resident states that probably has been that way for a while as he noted discomfort while sitting in wheelchair. ROHO was properly reinflated. Eldercare NP notified and saw resident on facility rounds. Received order to cleanse, then apply Santyl and foam border dressing daily and to have Integrated Wound Care (IWC) evaluate and treat on next rounding day. Resident is his own responsible party. -4/1/25 Weekly Bath Audit V9 completed noting open are on left buttock. Old dressing fell off and new dressing completed. -4/3/25 Interdisciplinary Team (IDT) met and reviewed wounds. Resident seen by ADON and LPN NM on 4/2/25. Currently monitoring unstageable pressure injury to left ischium which is new this week. See wound assessment for measurements and orders for treatment. Current interventions include ROHO cushion in w/c and foam mattress in bed, encourage to offload area while in bed. Will add to IWC rounds next week. -4/9/25 Skin and Wound Evaluation form identified a new, unstageable pressure ulcer but didn't have sections filled out for assessment and plan. No other assessments for that wound were located. During an interview on 4/14/25 at 5:57 p.m., R21 stated he had a sore on his bottom, it hurts sometimes but not right now. R21 said they changed the dressing every day. R21 was positioned with a pillow under the left hip. During an interview on 4/15/25 at 2:57 p.m., nursing assistant (NA)-C stated they were positioning R21 every hour when they could, but for sure before two hours. NA-C stated R21 did get up in the wheelchair sometimes, but not so much lately because of his sore, but he wasn't aware of anything special they needed to do with his cushion. NA-C stated he would either look at the care plan or ask someone to know how to care for residents. During an interview on 4/15/25 at 3:15 p.m., physical therapy assistant (PTA)-E confirmed he was currently working with R21 for range of motion in the upper and lower body. They have had to modify the lower body stretches because of the sore on his left buttock. PTA-E stated R21 has had the Roho cushion for as long as he has worked here. PTA-E said as he understands it, the cushion was found to be flat after resident had been using it, and an occupational therapist refilled it. PTA-E wasn't sure if any education was done with staff about the cushion and proper inflation, he would say to check inflation daily, especially if a resident has a sore. In PTA-E's opinion, R21 wouldn't be able to shift his weight on his own even if he was reminded, he needed physical assistance. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/25 at 3:34 p.m., NA-E stated she had not been taught anything about R21's Roho cushion, but she would just press on it before using it and if it was good and firm she would use it. If not, NA-E would report to the nurse. During an interview on 4/17/25 at 9:17 a.m., NA-D stated he knew there was a special cushion for R21's wheelchair but wasn't aware of anything special that needed to be done with it. During an interview on 4/17/25 at 12:14 p.m., licensed practical nurse (LPN)-B confirmed she was familiar with R21 and what they were doing differently since he had a wound was to make sure the Roho cushion was fully inflated. LPN-B added that a spare pump was in his room now, and they were all educated on making sure the cushion was full. LPN-B stated there wasn't repositioning on his care plan yet, they all just knew to reposition him, she would guess it is more frequent than every two hours. During an interview on 4/17/25 at 1:09 p.m., registered nurse (RN)-B nurse manager stated the intervention added to R21's care plan after he developed the wound was to check every week that the Roho cushion was fully inflated. RN-B stated therapy came up and made sure the cushion was properly reinflated after it was found to be flat, and some verbal education was done with floor nursing staff. RN-B stated she wasn't familiar with the Roho cushion manufacturer's directions but could look them up. The assistant director of nursing (ADON) added they relied on the standard of care for repositioning every two to three hours. The interventions on the care plan were all standard, but they could personalize it. The ADON stated the expectation was that weekly bath audits were done weekly, even if the resident refused their bath or shower, they should offer a bed bath, document, and still do the skin inspection. The ADON feels they may have been able to put interventions in sooner if the skin inspections had been done. During an interview on 4/17/25 at 3:53 p.m., the director of nursing (DON) stated it was her expectation to reposition residents routinely, which was every two to three hours, and she would expect skin inspections to be done weekly. The DON stated it would be impossible to say whether or not the wound would have been found sooner if weekly skin checks were done because they weren't done. A policy, Prevention of Pressure Injuries dated 9/29/21, identified its purpose was to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The policy indicated all residents at risk for or with actual pressure ulcers will be repositioned on an individualized schedule as determined by the interdisciplinary care team. A document submitted by the facility, Annual Education dated November 2024, identified mandatory education topics for NAs. Topics listed included positioning and wound reporting, but the document didn't contain information on the curriculum. Education material provided to staff regarding Roho cushion inflation was requested but not received.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview and document review, the facility failed to comprehensively assess prior to resident use of bed rails for 1 of 1 resident (R52) reviewed for bed rail use. Findings include: The Guidance for Industry and Federal Drug Administration (FDA) Staff, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment issued on 3/10/24, indicated a comprehensive assessment to prevent entrapment should be looked at when bedrails are considered for a resident. The comprehensive assessment included seven zones to look at and take measurements of which included the following: Zone 1: Within the rail Zone 2: Under the rail, between the rail supports or next to a single rail support. Zone 3: Between the rail and the mattress. Zone 4: Under the rail and the mattress. Zone 5: Between split bed rails. Zone 6: Between the end of the rail and the side edge of the head or footboard. Zone 7: Between the head or foot board and the mattress end. R52's quarterly Minimum Data Set (MDS) dated [DATE], indicated R52 had moderate to severe cognitive impairment. Diagnoses included dementia, Huntington's disease and depression. Section G- Functional Abilities and Goals indicated R52 had impairments to both sides of the upper and lower body and was dependent for all mobility needs. R52's care plan dated 4/17/25, indicated a physical mobility impairment related to Huntington's disease and intervention included assist resident to perform movements/tasks. It further identified an activity of daily living self-care need with interventions that included extensive assist of two staff to turn and reposition in bed. Bedrail in place to promote independence. R52's Bedrail Risk Assessment (BRA) dated 9/13/24, indicated four sections are looked at: - Section one looked at risk of climbing out of bed, resident confusion state and if bedrails present a higher risk to falling out of bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Section two looked at has an alternate to bedrails been looked at, can resident roll, slip or slide out of bed; has resident been consulted about rails; does resident understand the purpose for bedrails, is family involved. - Section three looked at is the resident small in stature, does the resident have a large head, is there a gab between the lower rail and the mattress will the bedrail fall off the bed and if any of the mentioned will create an entrapment hazard? - Section four looked at the gap between the bedrail and the headboard, if the bedrail fits correctly, is secure, is compatible with the bed and in working order. The BRA lacked information related to zone 1, Zone 2, the footboard portion of zone 6, and zone 7. The BRA also lacked documentation what alternatives were attempted prior to the use of bedrails. On 4/14/25 at 2:27 p.m., R52's bed was observed and there was a half bedrail attached to both sides of the bed, in the middle of each side of the bed. During an interview on 4/15/25 at 11:48 a.m., the maintenance supervisor (MS) stated when a request is made for a bedrails, they made sure there were provider orders entered into the resident medical record. Once orders were confirmed the bedrails would be placed on the bed. The MS stated they did not do any measurements or other items related to bed assessments that involved concerns related to entrapment. During an interview on 4/16/25 at 12:33 p.m., the administrator stated therapy department did the evaluations each time bedrails were recommended for a resident and assessments were completed based on policy. During an interview on 4/17/25 at 8:55 a.m., physical therapy assistant (PTA)-A stated she performed the bedrail assessments for all residents who had bedrails recommended to be placed. The assessment was performed on the same day maintenance placed the rails on the beds. There was a form that was filled out that looked at all parts of the bed and the bedrail to make sure everything is safe. Measurements were taken from the top of the rail to the headboard and then I made sure the gap between the bedrail and the mattress was no bigger than the width of my hand. There were no other measurements taken when risk of entrapment was looked at. PTA-A reviewed R52's BRA dated 9/13/24 and acknowledged she had performed that assessment and this was the most recent/last assessment she had completed. Facility policy Bed Safety and Bed Rails last reviewed 10/18/22, indicated bed frames, mattresses and bedrails would be checked for compatibility and size prior to use. Regardless of mattress type, width, length, and/or depth, bedframe, bed rail and mattress will leave no gap wide enough to entrap a residents head or body. Any gaps in the bed system are within the safety dimensions established by the FDA.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on interview and record review, the facility failed to ensure indications for use were identified for ordered medications in 1 of 5 residents (R26) reviewed for unnecessary medication. Findings include: R26's admission Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition with diagnoses of dementia, muscle weakness, Wernicke's encephalopathy (neurological condition caused by a lack of thiamine), hypertension, hypothyroidism, urinary incontinence, type 2 diabetes, and alcohol use in remission. R26's orders reviewed on 4/15/25, identified the following medication orders: -aspirin low dose oral tablet delayed release 81 mg- give one tablet by mouth once a day for analgesics-nonnarcotic -atorvastatin 40 mg- give one tablet by mouth at bedtime for antihyperlipidemics, chemicals -finasteride oral tablet 5 mg- give one tablet by mouth once a day for genitourinary agents, miscellaneous, dermatologicals -levothyroxine oral tablets 112 micrograms (mcg)- give one tablet by mouth once a day for thyroid agents, chemicals daily at 6:00 a.m. -pantoprazole sodium delayed release oral tablet 20 mg- give one tablet by mouth twice a day for ulcer drugs/antispasmodics/anticholinergics, chemicals -psyllium oral powder 28.3%- give one packet by mouth once a day for laxatives -solifenacin succinate oral tablet 5 mg- give one tablet by mouth once a day for urinary antispasmodics -tamsulosin oral capsule 0.4 mg- give two capsules by mouth once a day for genitourinary agents-miscellaneous -thiamine oral tablet 100 mg- give two tablets by mouth once a day for vitamins with supper -vibegron oral tablet 75 mg milligrams (mg)- give one tablet by mouth once a day for urinary antispasmodics During interview on 4/16/25 at 10:18 a.m., trained medication aide (TMA)-A stated medication orders typically have indication for use that can be seen on the medication administration record. TMA-A verified medications listed did not seem to have an indication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/16/25 at 10:24 a.m., registered nurse (RN)-B stated medications should have an indication for use listed. RN-B reviewed R26's medication list and verified lack of indications. During interview on 4/17/25 at 10:45 a.m., licensed practical nurse (LPN)-C stated an indication needs to be on the medication order and it is important for clarity of why a resident received medication. LPN-C stated the indication is usually one of a resident's diagnoses. During joint interview on 4/16/25 at 10:28 a.m., RN-C verified lack of indications for medication listed in R26's medical chart. Director of nursing (DON) and RN-C stated expectation for medication orders to have indications such as a diagnosis or condition.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview, and document review, the facility failed to ensure biologic medications were labeled with a pharmacy label indicating the resident's name and prescription information and to ensure biologic medications were destroyed after their beyond-use-date (BUD) in 1 of 3 medication carts reviewed for medication labeling and storage. This had potential to impact any resident receiving insulin in the Harbor Light community. Findings include: During an observation and interview on [DATE] at 1:45 p.m., in the Harbor Light community, licensed practical nurse (LPN)-D confirmed there was an insulin aspart ,d+[DATE] mix pen in the top drawer of the medication cart. LPN-D stated she was not aware of who this belonged to, they did go through the carts regularly for expired or beyond use medication. LPN-D confirmed with a printed resource on the medication cart indicating insulin aspart was good for 28 days after opening. LPN-D stated the insulin will be destroyed. During an interview on [DATE] at 3:56 p.m., the director of nursing (DON) stated she would expect insulin to be labeled with the resident's name, opened-on date and to be removed from use after it reaches the BUD. A policy, Labeling of Medication Containers dated [DATE], identified all medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. Medication labels must be legible at all times. Individual resident medications must include all necessary information such as resident name, prescriber's name, name, address, and phone number of pharmacy, name, strength and quantity of the drug, prescription number, date medication was dispensed, cautionary statements, the expiration date and directions for use. The expiration or BUD is checked prior to medication administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview and document review the facility failed to perform appropriate hand hygiene while doing a brief change for 1 of 1 resident (R52) reviewed for infection control. In addition, the facility failed to ensure a shared glucometer was cleaned and sanitized according to manufacturer's instructions for 1 of 1 resident (R78) reviewed for blood sugar testing, and to ensure hand hygiene and gloves were in place during eye drop administration for 1 of 4 residents (R64) reviewed for medication administration. Findings include: R52: R52's quarterly Minimum Data Set (MDS) dated [DATE], indicated R52 had moderate to severe cognitive impairment. Diagnoses included dementia, Huntington's disease and depression. Section G- Functional Abilities and Goals indicated R52 had impairments to both sides of the upper and lower body and was dependent for toileting hygiene. The MDS indicated R52 was always incontinent of both bowel and bladder. During observation on 4/15/25 at 1:38 p.m., nurse assistant (NA)-A and NA-B took R52 to his room from the dinning hall. NA-A and NA-B washed their hand and placed gloves on their hand and then transferred R52 to bed utilizing a hoyer lift. After transfer to bed NA-A and NA-B pulled R52's pants down and exposed his brief. NA-A undid the dirty brief and pulled the top down flat on the bed, but still under R52's buttocks. At the same time, without removing dirty gloves and hand washing, NA-B gathered the necessary equipment to clean R52. Without washing hands or changing gloves NA-A and NA-B cleaned both sides of R52's groin area with wet wipes. The dirty brief was then removed from under R52's bottom, R52 was turned to the right and then to the left, cleaning both sides while being turned. After cleaning was completed, NA-A placed a clean brief under R52's buttocks, R52 was rolled on his back and the brief was secured over R52's groin area without removing the soiled gloves, washing hands and putting new clean gloves on. R52's pants were then placed back on. Lastly R52 was lifted back into his chair. At this point NA-A and NA-B removed their dirty gloves and washed their hands. During an interview on 4/14/25 at 1:54 p.m., NA-A and NA-B stated they would not change gloves or wash their hands except at the beginning and the end of providing peri cares. The only time they would change gloves and wash hands during the process of provided peri cares would be if the glove or skin encountered actual stool. During an interview on 4/16/25 at 2:08 p.m., the infection preventionist/assistant director of nursing (IP) stated gloves needed to be changed and hands washed anytime they were going from dirty to clean when providing peri care. Example given was when the staff finished brief removal and cleaning of the peri area, hands would need to be washed, and gloves changed before placing the new clean brief on the resident. Facility policy Handwashing/Hand Hygiene last updated 8/25/21, indicated hand washing or utilizing alcohol based hand rub would be used: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A: before and after coming on duty. B: before and after direct contact with residents. C: before handling clean or soiled dressing, gauze pads etc: D. before staff moved from a contaminated body site to a clean body site during resident cares. 48109 R78: R78's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and a diagnosis of diabetes mellitus. R78's medical record identified an order dated 10/2/24, for blood sugar testing two times per day. During an observation and interview on 4/16/25 at 7:27 a.m., licensed practical nurse (LPN)-B checked blood sugar for R78 with a facility glucometer. When finished, LPN-B carried the glucometer back to the medication cart, cleaned it with an alcohol wipe and then set it on top of the cart. LPN-B stated the glucometer was shared between two residents, the rest of the residents either had their own meter or a continuous blood glucose monitor. LPN-B stated her process was to wear gloves when she was using the meter and then to clean it with an alcohol wipe. R64: R64's quarterly MDS dated [DATE], identified moderately impaired cognition and diagnoses of hypertension, renal failure, depression and COPD. R64's medical record identified an order dated 2/11/25, for Refresh Liquigel (brand name ophthalmic solution) one drop to both eyes four times per day for dry eyes. During an observation and interview on 4/16/25 at 7:40 a.m., trained medication aid (TMA)-B prepared to assist R64 with Refresh Liquigel. TMA-B got a tissue, leaned R64 back in her chair, tilted her head back, used his left hand to hold her right eye open and applied a drop, he was not wearing gloves. TMA-B then used one hand to hold her left eye open and the other to place one drop in her left eye. R64 stated the drop didn't get in her eye, TMA-B repeated the process and then handed R64 a tissue. TMA-B stated he wore gloves sometimes but not for R64 because she got scared. TMA-B stated it was important to wear gloves when giving eye drops to protect from germs. During an interview on 4/16/25 at 11:46 a.m., licensed practical nurse (LPN)-A stated he would use purple top wipes to clean the glucometer if he used it, but he hasn't had to use it because the residents on his side either have a CGM or their own glucometer. During an interview on 4/17/25 at 1:28 p.m., the assistant director of nursing (ADON) stated she didn't expect anyone to have a shared glucometer, and if there were she would expect it to be cleaned with purple-top wipes. The ADON also stated she would expect clean hands and gloves when administering eye drops. These were important for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Administering Medications dated 12/13/21, identified staff will follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable. A policy, Obtaining a Fingerstick Glucose Level dated 9/30/21, identified to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The manufacturer's instructions for the Medline Evencare G2 blood glucose system included two steps. The first step was to clean the machine of any visible soil with a soft cloth and a mild detergent. Cleaning must be done to ensure proper disinfection in the next step. Step two was to disinfect the meter with one of the products validated for use with their meter, listed as: Dispatch Hospital Cleaner Disinfectant towels with bleach, Clorox Healthcare Bleach germicidal and disinfectant wipes, Medline Micro-Kill Bleach germicidal bleach wipes. The glucometer should remain wet with the product for the amount of time designated by product instructions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Residence and Rehabilitation Center	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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview and document review, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program 1 of 1 resident (R52) reviewed for bed rail safety. Findings include: R52's quarterly Minimum Data Set (MDS) dated [DATE], indicated R52 had moderate to severe cognitive impairment. Diagnoses included dementia, Huntington's disease and depression. Section G- Functional Abilities and Goals indicated R52 had impairments to both sides of the upper and lower body and was dependent for all mobility needs. R52's care plan dated 4/17/25, indicated a physical mobility impairment related to Huntington's disease and intervention included assist resident to perform movements/tasks. R52's care plan last updated 4/15/25, indicated an activity of daily living self-care need with interventions that included resident is an extensive assist of two staff to turn and reposition in bed. A bedrail in place to promote independence. On 4/14/25 at 2:27 p.m., R52's bed was observed and there was a half bedrail attached to both sides of the bed, in the middle of each side of the bed. During an interview on 4/15/25 at 11:48 a.m., the maintenance supervisor (MS) stated when a request is made for a bedrail, they made sure there were provider orders entered into the resident medical record. Once orders were confirmed the bedrails would be placed on the bed. The MS stated they did not do any measurements or other items related to bed assessments that involved concerns related to entrapment. There was no schedule for regular bed inspections, mattresses, or bedrails other than to check the bedrails for looseness and tighten them every month. During an interview on 4/17/25 at 8:55 a.m., physical therapy assistant (PTA)-A stated she performed the bedrail assessments for all residents who had bedrails recommended to be placed. The assessment was performed on the same day maintenance placed the rails on the beds. PTA-A stated there were no routine evaluations performed to make sure there were no changes to a resident's risk to entrapment. During an interview on 4/17/25 at 11:08 a.m., the administrator stated maintenance performed monthly inspections of the bed and bedrail through the TELS system. Facility policy Bed Safety and Bed Rails last reviewed 10/18/22, indicated maintenance staff routinely inspected all beds and related equipment to identify risks and problems including entrapment risks. The maintenance department would provide a copy of inspections to the administrator and report results to the QAPI committee for appropriate action. Copies of the inspection results and QAPI committee recommendations were maintained by the administrator and /or safety committee. Maintenance records for regular bed inspection and maintenance was requested, but not received.