Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 16, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: May 11, 2023

Dear Administrator:

On July 7, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 16, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

Re: Reinspection Results
Event ID: BSGS12

Dear Administrator:

On July 7, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 13, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: May 11, 2023

Dear Administrator:

On May 11, 2023, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 11, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 11, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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 electronic 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING ______ B. WING ______	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE MANOR LLC	640 THIRD STREET GAYLORD, MN 55334

(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
E 000	Initial Comments On 5/8/23 through 5/11/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/8/23 through 5/11/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H54732088C (MN00087517) H54732090C (MN00086351) H54732091C (MN00084339) H54732108C (MN00088066) H54739135C (MN00091604) H54739921C (MN00092249) The following complaints were reviewed. H54732026C (MN00093129 and MN00093241) with a deficiency issued at F580 H54732031C (MN00090107) with a deficiency issued at F688 and F725	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/19/2023

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.

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 000	Continued From page 1 H54732089C (MN00086778) with a deficiency issued at F677, F686, and F725 H54732102C (MN00093219) with a deficiency issued at F580 H54732106C (MN00090098) with a deficiency issued at F725 H54732107C (MN00090102) with a deficiency issued at F725 H54732109C (MN00087632) with a deficiency issued at F689 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	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	F 550		6/30/23

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 550

Continued From page 2
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 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 observation, interview and document review the facility failed to provide a dignified dining experience for 4 of 4 residents (R24, R15, R26 and R3) who required supervision and assistance with dining.

Findings Include:

During observation on 5/8/23, at 12:27 p.m., R26 and R3 sat at one table with beverages in front of

F 550

F550

Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed

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 550	Continued From page 3 them with food just delivered. R24 and R15 sat at the next table with food delivered at 12:25 p.m. R3, R24 and R15 made no attempt to eat. Trained medication assistant (TMA)-A sat with R26 to assist with meal. No encouragement was offered to R24, R15 or R3 to eat. At 12:43 TMA-A indicated to R26 she would be right back and went to the nurses station and began passing medications. At 12:52 p.m. nursing assistant (NA)-A arrived into dining area and stood next to R3 and assisted R3 with a forkful of vegetables. NA-A went to the next table, assisted R15 with a forkful of hamburger hotdish. Next, NA-A assisted R24 to take a bite but R24 refused. At 12:54 p.m., NA-A went to kitchen area. At 12:55 p.m., NA-A returned, and while standing, gave R3 another bite of food. She went to R24 to try to give a bite of food, which she again refused. At 12:56 p.m., R26 attempted to get a spoonful of hotdish, but was not successful. At 12:57 p.m., NA-A went back to R3 and gave her another bite of vegetables. At 12:58 p.m. NA-A returned to R24 and attempted to give her a forkful of food which she again refused. R15 made no attempt to eat. At 1:00 p.m., NA-A left the dining room and returned at 1:03 p.m. She attempted to assist R26 and R3, both refused. At 1:05 p.m., Na-A went to kitchen area, returned, and assisted R3 with a spoonful of desert. She went to another table, encouraged R24 and R15 to eat. At 1:08 p.m., NA-A left the floor. R24, R15, R26, and R3 made no further attempt to eat. Food was not offered to be reheated. NA-A remained standing throughout meal process. There were no other staff present in the dining room throughout this time. R24's face sheet printed 5/11/23, identified a diagnoses of Alzheimer's disease, and dysphagia	F 550	in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents are provided with a dignified dining experience. -Residents residing in this facility who require supervision and assistance with dining have the potential to be affected. -Education will be provided to necessary Bayside Manor staff utilizing Monarch Healthcare Policy and procedure. -Necessary staff have been reeducated to this rule and regulation. R24, R15, R3, R26, along with all other residents who require assistance with eating are being assisted at all meals in a manner that is	

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F 550	Continued From page 4	F 550		

(difficulty in swallowing food or liquid).

R24's quarterly, Minimum Data Set (MDS) assessment, dated 1/31/23, identified severe cognitive impairment, and required supervision of one person to physical assist for eating.

R24's care plan dated 1/20/23, identified an alteration with nutrition related to mechanically altered diet and requires supervision to limited to extensive assist, requiring cueing, assist to eat.

R15's face sheet printed 5/11/23, identified a diagnoses of Alzheimer's disease, dementia with behavioral disturbance and generalized weakness.

R15's admission MDS assessment dated 4/18/23, identified severe cognitive impairment, and required supervision of one person physical assist.

R15's care plan dated 4/9/23, identified a problem with self-care performance of activities of daily living and is independent with eating after set up. Eats slow, needs encouragement

R26's face sheet printed 5/11/23 indicated diagnosis of Alzheimer's disease, diabetes mellitus and dementia with behavioral disturbance.

R26's admission MDS assessment dated 5/1/23 indicated severe cognitive impairment and required extensive assistance of one personal physical assist for eating.

R26's care plan dated 4/25/23, indicated an alteration in activities of daily living and required

Provider's Plan of Correction (F 550):

both dignified and meets the definition of this regulation. Appropriately trained staff are at the table with residents who meet this definition and will stay with them until they are finished with their meal. Monitoring meal service will include, but is not limited to, timeliness of service and ensuring appropriate meal temperatures for optimal enjoyment.

-Audits will be completed five (5) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audits results will be received at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.

-Director of Nursing or designee is responsible party.

-Corrective action will be completed by 06/30/2023.

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F 550	Continued From page 5 extensive assist of 1 with eating. R3's admission record, printed 5/11/23, identified a diagnoses of Alzheimer's disease, and dementia with behavioral disturbance. R3's annual MDS dated 3/1/23, indicated severe cognitive impairment and required supervision of one person physical assist with eating. R3's care plan dated 3/1/23 indicated an activities of daily living deficit and requires supervision with setup and cues and assist as needed. During an interview on 5/8/23, at 2:31 p.m., NA-A stated there were only two NA's in the facility until noon when she arrived. She called for assistance in the dining room twice without any response from the other nursing staff members. NA-A stated there were two residents that required feeding at one table and the other two require supervision and encouragement to eat. NA-A stated "we needed more help in the dining room today than we had". During interview on 5/10/23 3:08 p.m., the director of nursing (DON) stated on Monday 5/8/23, staffing was a challenge as she was unaware the facility was short. The DON confirmed NA's were expected to sit while assisting residents with meals and food should be reheated when sitting longer than 5-10 minutes.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561		6/30/23

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 561	Continued From page 6 through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure identified preferences for rising were honored and implemented for 1 of 1 resident (R28) reviewed for choices. Findings include: R28's quarterly Minimum Data Set (MDS) dated 3/20/23, indicated R2 had moderate cognitive impairment and demonstrated no physical, verbal or other behavioral symptoms; required	F 561	F561 s/s D Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	

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F 561	Continued From page 7 two-person physical assist with bed mobility, transfer, toilet use; one person physical assist with dressing, personal hygiene; utilized a walker and wheelchair. Diagnoses included: depression, urinary incontinence, obesity, osteoarthritis of hip (breakdown of joint cartilage and underlying bone), and heart failure. R28's care plan dated 3/27/23, indicated ADL (activity daily living) self-care performance deficit r/t (related to) heart failure, bilateral osteoarthritis of the hips, trochanteric bursitis left hip, obesity, bilateral primary osteoarthritis of knee, and cognitive impairment. Interventions included: neat, clean, and odor free with assistance from staff; maintain current level of function; and extensive A1 (assist of one) with dressing, grooming, bathing, and eating. Get resident up on NOC (night) shift, and prefers to be up in dining room around 6:00 a.m. Progress note dated 5/4/23 at 2:31 p.m., health information management (HIM)-F indicated, "Writer was helping check call lights and checked with resident to see what he needed. He wanted to talk to someone about the fact that he wants to get up early, between 5 and 5:30 and have breakfast early per his care-plan. He was in bed today until at least 10 and did not get to eat until 10:30 and eluded to the fact that it has happened more than once recently. Writer assured him that I would notify the appropriate people to ensure the plan is followed was helping check call lights and checked with resident to see what he needed. He wanted to talk to someone about the fact that he wants to get up early, between 5 and 5:30 and have breakfast early per his care-plan. He was in bed today until at least 10 and did not get to eat until 10:30 and eluded to the fact that it	F 561	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed, to ensure resident preferences are honored and implemented for rising. -All residents who require assistance with ADL's have the potential to be affected. -The plan of care for all residents who require assistance with ADL's was reviewed and revised as needed to ensure preferences are accurately documented. -All necessary Bayside Manor staff providing direct care to residents will receive education on resident preferences and where to locate this in the plan of care.	

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has happened more than once recently. Writer assured him that I would notify the appropriate people to ensure the plan is followed."

Progress note dated 4/27/23, at 6:50 p.m. licensed practical nurse (LPN)-B indicated, R28 stated "I want to get up early in the morning and go out for breakfast but I haven't been able to make it on time."

Grievance summary dated 1/23/23, indicated R28 had requested to get up between 6:00 and 7:00 a.m., was still not up at 9:00 a.m., ate breakfast at 10:15 a.m., and then was not hungry for lunch. Grievance indicated actions taken included R28 was placed on the overnight aide list of residents to get up as it was R28's preference to get up early.

Grievance summary dated 5/4/23, indicated R28 preferred assistance to the dining room between 5:00 and 5:30 a.m., and it was not happening. Summary of action taken indicated DON added to the care plan to get R28 up on night shift and in the dining room around 6:00 a.m.

On 5/08/23 at 2:40 p.m., R28 stated preferance was to get out of bed shortly after 6:00 a.m. R28 stated 3 out of 7 days of the week he was not provided assistance with morning cares and laid in bed until 10:00 a.m.

On 5/09/23 at 9:49 a.m., family member (FM)-G stated last weekend R28 was not up or assisted out of bed until 10:00 a.m. Staff was questioned, and she was told the facility was "short staffed."

On 5/10/23 at 11:18 a.m., the director nursing (DON) stated residents had the right to choose

F 561

-Education will be provided to necessary Bayside Manor staff utilizing Monarch Healthcare Policy and procedure.

-Nursing and Social Services met with R28 to discuss rising preferences. R28s rising preferences are updated and reflected on Kardex.

-Care plans and Kardex will be updated to reflect preferences upon admission and updated at least quarterly thereafter.

-Audits will be provided two (2) times per week for two (3) weeks; one (1) time per week for (2) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of the occurrence.

-Social Service Director or designee is responsible party.

-Corrective action will be completed on or before 06/30/2023.

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F 561	Continued From page 9 rising time, expected staff assisted, and honored the preferences. Facility Policy titled Quality of Life - Resident Self Determination and Participation dated 12/16, indicated: Policy Interpretation and Implementation 1. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments and plans of care, including: a. Daily routine, such as sleeping and waking, eating, exercise and bathing schedules. b. Personal care needs, such as bathing methods, grooming styles and dress. 2. In order to facilitate resident choices, the administration and staff: a. Inform the residents and family members of the residents' right to self-determination and participation in preferred activities. b. Gather information about the residents' personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record. c. Include information gathered about the resident's preferences in the care planning process; and d. Document and communicate any medical conditions or limitations that may inhibit or interfere with participation in preferred activities.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		6/30/23

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F 580	Continued From page 10 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide the physician with all available clinical information for a significant physical change for 1 of 1 residents (R136) who was reviewed for notification of change.

Findings include:

R136's facesheet printed on 5/10/23, indicated admission on 3/4/23 and included diagnoses of surgical aftercare for surgery on the nervous system, discitis (infection of intervertebral disc space), psoas (long muscle in the back) abscess, diabetes, and chronic kidney disease.

R136's admission Minimum Data Set (MDS) assessment dated 3/10/23, indicated: R136 was cognitively intact, had adequate vision and hearing, clear speech, could understand and be understood. R136 required extensive assistance of two staff for bed mobility, transfers, and toileting. R136 did not walk.

R136's care plan dated 3/4/23 indicated R136 would be free from symptoms of UTI (urinary tract infection). The care plan did not identify potential symptoms of UTI for staff to monitor. Further, the

F 580

F580 s/s D:

Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is

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F 580	Continued From page 12 care plan indicated R136 was at risk for alteration in cognition related to diagnoses. R136 was Spanish speaking but knew some English and was his own decision maker. Staff were to document changes in orientation. R136 physician orders included: 3/3/23 - Ceftriaxone, generic name for Rocephin, (treats infections), 2 gm (grams) intravenously daily for psoas abscess, discitis. 3/3/23 - Metformin (anti-diabetic medication) 1000 mg twice a day for hyperglycemia (high blood sugar levels). 3/4/23 - Blood sugars before/after meals and bedtime four times a day for DM (diabetes mellitus). 3/27/23 - Obtain urine sample for UA (urinalysis) related to burning with urination. Fax results to provider. 3/30/23 - UTI progress note every shift for 14 days. 3/30/23 - Levofloxacin (treats infections) 500 mg, one tablet daily for UTI for 14 days. During record review, the following fax communications indicated: On 3/26/23 at 6:00 a.m., a Fax indicated the last two nights R136 had a hard time starting flow of urine and pain in the bladder. Only small amount of urine with each attempt using the urinal. (According to nursing progress notes, this fax was sent to medical provider (MP)-I the following day 3/27/23 at 1:58 p.m.). The same day (undetermined time), a fax was received from (MP)-J to check a UA and fax results. Four days later, on 3/30/23 at 10:11 a.m., a Fax indicated UA results were faxed to MP-I. The	F 580	submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed to ensure a physician is provided all available clinical information for a significant physical change in a resident. -All residents in the facility have the potential to be affected if this requirement is not met. -All residents were reviewed for the need to make necessary notifications to the physician. - R136 has discharged from the facility. -Necessary staff have received education on ensuring physician is provided with all clinical information for a physical change of condition in a resident. -The facility QAPI team reviewed the CMS-2567 and POC during the June 2023 meeting. -Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; weekly for two (2) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is	

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same day (undetermined time), a fax was received from MP-J indicating the UA had some [illegible word] findings for infection versus prostatitis. Levofloxacin 500 mg once a day for 14 days was started. R139 was to follow up in clinic if no improvement.

Urinalysis results dated 3/28/23 and 3/29/23 indicated R136's urine had abnormal findings including cloudy urine, positive for blood, ketones (may indicate body is too acidic), protein (a sign kidneys are damaged) and presence of white blood cells and bacteria. A urine culture (UC) dated 3/31/23 indicated no growth.

Progress notes indicated, nurses documented a sequence of events from 3/26/23 through 3/30/23 in which they informed providers MP-I and MP-J of R136's painful urination, bladder pain and possible urinary retention (difficulty urinating and completely emptying bladder) via fax. However, nursing staff did not communicate other physical changes in R136's condition that had been documented in progress notes, including nausea, back pain, confusion, and hallucinations. Progress notes did not indicate a comprehensive nursing assessment had been conducted to pull together all available information and report it to a provider.

Furthermore, there was delay from the first time R136 reported painful urine to the final UA being resulted. Nursing progress notes indicated the following four-day timeline:
1) 3/26/23 at 5:51 a.m., R136 experienced painful urination and voided a small amount.
2) 3/27/23 at 1:41 p.m., R136 experienced [urinary] frequency and urgency. Message left with MP-I.

responsible party.

-Corrective action will be completed on or before 6/30/23

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3) 3/27/23 at 1:58 p.m., fax to MP-I regarding burning with urination.
4) 3/27/23 at 3:43 p.m., order received from MP-J for UA.
5) 3/27/23 at 3:56 p.m., clinic was contacted for an order for which method to obtain the UA; clean catch or straight cath (catheterization - inserting a tube into bladder).
6) 3/28/23 at 11:03 a.m., 19 hours after the order for the UA was received, an order for a catheterized specimen was received. The specimen was obtained and delivered to the lab (laboratory).
7) 3/29/23 at 1:27 p.m., a call from the lab informed the facility a UC was needed as one had not been ordered with the initial UA order. Another UA would need be obtained in order to do a UC.
8) 3/29/23 at 11:20 p.m., a second UA was obtained.
9) 3/30/23 at 8:18 a.m., the urine specimen was delivered to the clinic lab.
10) 3/30/23 at 12:24 p.m., the UA results were faxed to MP-I and an order was received for an antibiotic.

On 3/31/23 from approximately 12:00 midnight to 3:30 a.m., R136's condition began to deteriorate. R136 experienced a drop in blood sugar to 30 mg/dL (milligram per deciliter), developed 10/10 abdominal pain, low blood pressure of 92/36, elevated pulse of 106 beats per minute, and increased respiratory rate of 36 breaths per minute. During this time, the nursing staff was in contact with the DON and the emergency department (ED) at a nearby hospital. At 3:30 a.m., R136 was transferred to the ED. On 3/31/23 at 11:33 a.m., the facility received a call from the ED at the nearby hospital informing them R136

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was septic and in DKA (diabetic ketoacidosis - a diabetes complication where the body produces excess blood acids, or ketones and can be triggered by infection) and would be transferred to a larger hospital. On 3/31/23 at 7:30 p.m., the facility was informed by the larger hospital that R136 had passed away.

During an interview on 5/11/23, at 10:31 a.m., the timeline above from 3/26/23 to 3/30/23 was reviewed with regional nurse consultant (RNC)-H and the director of nursing (DON). RNC-H acknowledged the timeline was accurate. RNC-H acknowledged there was a potential delay in treatment for R136. RNC-H stated part of the delay was due to nurses being cautious and wanting the provider to order the preferred method of obtaining the urine specimen - clean catch or straight cath. Further, RNC-H stated the delay was partially attributed to MP-J ordering only a UA on 3/27/23 and not also a UC. The DON who was new to her role during this timeframe, was aware R136 was transferred to the hospital on 3/31/23. However, the DON had not been aware of the clinical changes of confusion and hallucinations R136 experienced in addition to UTI symptoms during the time frame of 3/26/23 to 3/30/23.

During the same interview, RNC-H and the DON stated they would have expected nurses from 3/26/23 to 3/30/23 to have looked at the bigger picture of all symptoms R136 was experiencing - back pain, confusion, and hallucinations, in addition to UTI symptoms, and perform a comprehensive nursing assessment. Following the assessment, contact a provider with the information.

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On 5/11/23 at 11:38 a.m., surveyor left a telephone message with clinic triage nurse for MP-I, including purpose of call, R136's name, date of birth, and requested a call back. Triage nurse stated she would forward message to MP-I. Intent of phone call was to discuss timeline from 3/26/23 to 3/30/23 and rapid deterioration on 3/31/23.

During an interview on 5/11/23 at 12:36 p.m., licensed practical nurse (LPN)-A who worked the day shift the week of 3/26/23 to 3/30/23 was not involved in the direct care of R136, but was involved with fax and phone communication between the facility, MP-I and MP-J to obtain the UA. LPN-A did not know if nursing staff on duty contacted a provider with the additional symptoms R136 had experienced including nausea, confusion and hallucinations in addition to abdominal pain and painful urination. LPN-A stated with multiple symptoms, she would have expected nursing staff to conduct an assessment, including assessing for bladder distention, possibly requesting an order for a residual urine (the amount of urine remaining in the bladder after urination), assess R136's oral intake against urine output, listen to bowel sounds, assess color and characteristics of R136's urine, assess vital signs, and then contact a provider with that information. LPN-A added, I would inform him what I found and ask if he wanted to initiate anything prior to receiving the UA results. LPN-A did not know why this had not been done.

During an interview on 5/11/23 at 2:35 p.m., RNC-H reaffirmed she would have expected nursing staff to notify a provider as soon as new symptoms were identified the week of 3/26/23 to 3/30/23. RNC-H indicated that upon admission,

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R136 had elected to keep his personal medical provider, MP-I, rather than utilize the providers who regularly saw residents at the facility. RNC-H stated most communication with MP-I and MP-J were conducted via fax.

On 5/11/23 at 4:44 p.m., surveyor placed a second call to clinic for MP-I. Was informed the earlier message had been given; no need to leave another message. As of 5/15/23 at 4:00 p.m., no return call had been received.

On 5/11/23 at 5:00 p.m., towards the end of the survey, the DON provided paper copies of clinic telephone encounters between MP-J, clinic nurses and nurses at the facility from 3/27/23 to 3/28/23. The encounters further identified a delay in obtaining and resulting the initial UA. A total of 10 phone calls took place between the facility and the clinic. From the first phone call on 3/27/23 at 1:43 p.m., when the facility called the clinic requesting a UA, to the last phone call on 3/28/23 at 10:37 a.m., with the order for the size urinary catheter to use, a total of 20 hours elapsed. Of those 20 hours, more than 17 hours were from the facility not answering a phone call from the clinic on 3/27/23 at 4:57 p.m., with the order to obtain a straight cath urine specimen. The clinic called back the next morning with that order.

The size urinary catheter was within the scope of practice for a nurse to determine using facility policy and/or textbook or online clinical reference material. In addition, nursing staff failed to organize their thoughts and questions when contacting the provider to request a UA for R136 (whether to obtain a clean catch or straight cath specimen and what size urinary catheter to use). This failure resulted in multiple phone calls and a

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F 580	Continued From page 18 20-hour delay. This delay was in addition to the delay incurred when the lab requested a second UA in order to do a UC. Facility policy titled Change in a Resident's Condition or Status, undated, indicated the facility would promptly notify the physician/health provider of changes in the residents medical condition. The nurse would notify the residents attending physician or physician on-all when there had been a significant change in the residents physical/emotional/mental condition. Prior to notifying the physician or healthcare provider, the nurse would make detailed observations and gather relevant and pertinent information for the provider. Except in medical emergencies, notifications would be made within 24 hours of change occurring in the residents medical/mental condition or status. If a significant change in the resident physical or mental condition occurred, a comprehensive assessment of the residents condition would be conducted.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dependent residents receive assistance with personal hygiene and activities of daily living (ADL's) for 2 of 9 residents (R8, R15) who were dependent on staff for personal hygiene.	F 677	F677 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of	6/30/23

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F 677	Continued From page 19 Findings include: R8's quarterly Minimum Data Set (MDS) dated 4/18/2023, indicated: severe cognitive impairment; required one-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene; utilized a wheelchair; no rejected care behaviors. Diagnoses included: pulmonary fibrosis (lung disease that causes lung tissue to scar, thicken, and stiffen), Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication (spinal nerves get compressed in the lower spine), osteoarthritis of hips, depression, and dementia. R8's care plan dated 4/7/23, indicated: ADL self-care performance deficit r/t (related to) pulmonary fibrosis, Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication, osteoarthritis of hips, depression, dementia; interventions included: extensive A1 (assist of one) with dressing, grooming, bathing, eating,); shower/bath Wednesday am with hospice, Saturday pm with NAR (nursing assistant). R8's progress notes lacked evidence of any refusal of care. On 5/08/23 at 1:41 p.m., R8 was observed with white and black chin hairs of varied lengths (approximately ½ inch). R8 stated she would like her chin hairs shaved "to look like a lady." R8 stated shaving was not offered or completed by staff. On 5/09/23 at 10:12 a.m., R8 was observed seated in a wheelchair, in the day room with long chin hairs visible. Nursing assistant (NA)-A stated	F 677	fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed to ensure all residents receive assistance with grooming, personal and oral hygiene tasks. -All residents in the facility have the potential to be affected if this requirement is not met. - R8 has been shaved. R15 receives assistance with grooming, personal and oral hygiene tasks. -The plan of care for all residents who require assistance with grooming,	

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F 677	Continued From page 20 R8's morning cares were completed by night shift. On 5/10/23 at 10:14 a.m., the director of nursing (DON) stated shaving of residents was expected with morning cares and when facial hair was observed. R8 told the DON she wanted the facial hair shaved. The DON confirmed R8's chin hairs were long and needed shaving and confirmed staff had not completed the task for R8. On 5/10/23 at 10:16 a.m., trained medication aide (TMA)-A stated staff who provided morning cares were expected to shave the residents when facial hair was visible. TMA-A stated overnight shift provided R8 with morning cares. On 5/10/23 at 12:12 p.m., NA-C stated night shift provided R8's morning cares and was dependent on staff assistance with facial hair removed. NA-C stated residents were expected shaved when long chin hairs were visible. R15's quarterly Minimum Data Set (MDS) dated 4/18/20/23, indicated severe cognitive impairment; required one-person physical assist with bed mobility,dressing, eating, toilet use, personal hygiene, two person physical assist with transfer, and utilized a walker. Diagnoses included: heart failure, Alzheimer's disease, depression, muscle weakness, and history of falling. R15's care plan dated 5/10/23, indicated an ADL self-care performance deficit r/t Alzheimer's, dementia, heart failure, COPD, weakness; resident will be neat, clean and odor free with assistance from staff. Interventions included extensive A1 with dressing and grooming;	F 677	personal and oral hygiene tasks have been reviewed and revised as needed to ensure compliance and are appropriately followed. - NAR guides for all residents who require assistance with grooming, personal and oral hygiene tasks have been reviewed and revised as needed to ensure compliance. -Necessary staff have received education on expectations of assistance with grooming, personal and oral hygiene for residents. -The facility QAPI team reviewed the CMS-2567 and POC during the June 2023 meeting. -Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; weekly for two (2) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 6/30/23	

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F 677	Continued From page 21	F 677		

extensive A2 with bathing; eating independent after set up, ensure out for meals to dining room, and eats slow.

On 5/08/23 at 9:35 a.m., R15 was lying in bed and further indicated had not eaten breakfast.

On 5/08/23 at 12:32 p.m., observed NA-C enter R15's room, changed R15's brief and walked with R15 through the hallways and proceeded to the dining room for lunch. NA-C stated she was unaware if R15 was provided morning ADL cares or ate breakfast. NA-C was unsure whose responsibility R15's morning cares were today.

On 5/08/23 at 3:48 p.m., the DON confirmed staff had not provided R15 morning cares or breakfast today and stated the disruption of the schedule caused staff to fall behind with morning cares. DON stated R15 was provided an afternoon shower.

On 5/10/23 at 1:31 p.m., NA-A confirmed on 5/8/23, she arrived at work around 12:00 p.m. and R15's morning cares nor breakfast had been provided prior to her shift.

On 5/11/23 at 9:22 a.m., the DON stated staff were expected to assist residents with morning cares. Residents were not expected to still be in bed at 10:00 a.m.

On 5/11/23 at 9:48 a.m., R15 was observed in her bed under the covers.

On 5/11/23 at 10:35 a.m., licensed practical nurse (LPN)-A stated her shift "just" started and confirmed R15 was not assisted with breakfast or morning cares today.

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F 677	Continued From page 22	F 677		

On 5/11/23 at 10:37 a.m., NA-B verified she had not had time to complete R15's morning cares today. NA-B stated R15 was dependent on staff for ADL cares and was expected to have had breakfast already.

On 5/11/23 at 11:41 a.m., R15 was seated in the dining room and ate breakfast.

Facility policy titled Activities of Daily Living (ADLs)/ Maintain Abilities Policy dated 3/31/23, indicated:

Intent: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

3. The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems.

4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such

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F 677	Continued From page 23 emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement bowel movement (BM) protocol for 1 of 1 resident (R8) reviewed for constipation. Findings include: R8's quarterly Minimum Data Set (MDS) dated 4/18/20/23, indicated severe cognitive impairment, required one-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair, and no rejected care behaviors. Diagnoses included: pulmonary fibrosis (lung disease that causes lung tissue to scar, thicken, and stiffen), Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication (spinal nerves get compressed in the lower spine), osteoarthritis of hips, depression, dementia; and frequently incontinent of bowel.	F 684	F684 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to	6/30/23

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F 684	Continued From page 24 R8's care plan dated 4/7/23, indicated function bowel and bladder incontinence and interventions included extensive assist of one, toilet resident upon rising, after meals, before bed, check/change on night rounds. Review of R8's bowel movement (BM) report indicated: 3/28/23, at 9:59 p.m. large, formed bowel movement. 3/29/23, no bowel movement, 3/30/23, no bowel movement 3/31/23, no bowel movement 4/1/23, no bowel movement, (4th day) 4/2/23, large, formed bowel movement. 4/8/23 at 1:59 p.m., medium formed BM. 4/9/23, no bowel movement 4/10/23, no bowel movement 4/11/23, no bowel movement 4/12/23, no bowel movement 4/13/23, no bowel movement. (5th day) 4/14/23, medium formed/normal and large formed/normal BM. 4/21/23 at 8:15 a.m., R8 had a medium BM. R8's next documented BM was on 4/28/23 at 9:02 a.m. (6 days later). Review of R8's medical record did not include evidence of attempted interventions related to R8's bowel movements. On 5/08/23 at 2:15 p.m., R8 was seated in a wheelchair and indicated problems with constipation. R8 was not able to discuss more specifics related to bowel movements or constipation.	F 684	the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed to ensure residents are being monitored for having regular bowel movements and that there are appropriate interventions in place to treat if constipation is indicated. -All residents in the facility have the potential to be affected if this requirement is not met. - R8 has bowel movements monitored daily and standing orders are in place that direct staff on how to treat if there is no bowel movement for 3 days. -All residents' bowel movements are being monitored daily and have standing orders in place to direct staff on how to treat if there is no bowel movement for 3 days. -Necessary staff have received education on the process of monitoring of bowel movements and how to treat if indicated. -The facility QAPI team reviewed the CMS-2567 and POC during the June 2023 meeting.	

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F 684	Continued From page 25 On 5/10/23 at 11:58 a.m., nursing assistant (NA)-C confirmed all direct care staff were responsible for recording when a resident had a BM. NA-C stated the nurse was responsible to monitor resident's bowel movements. On 5/10/23 at 6:53 p.m., licensed practical nurse (LPN)-D confirmed NA's and nursing charted when a resident had a bowel movement and it was nursing's responsibility to monitor. Further, when a resident went three days without a bowel movement, staff offered prune juice or whatever the resident had available as needed and followed the standing bowel protocol orders. LPN-D stated the nurse on the night shift was responsible for reviewing the BM report for the residents and passed the information on to the day staff. On 5/10/23 at 6:33 p.m., during an interview the DON verified R8 went four days, five days, and six days per the documentation of R8's medical record with no bowel movement. The DON further verified no stool softeners or constipation relieving medications were given per the MAR. DON stated residents' expectations for bowel management were nursing to follow the standing orders. The DON stated the facility's bowel management standing orders did not specify the day to initiate the bowel program. The DON stated nursing judgement was expected to initiate a bowel assessment and documentation related to the bowel interventions. The DON confirmed standing orders were expected initiated by nursing after residents with no bowel movement after three days, documentation of an assessment, or resident refusal. The DON stated nursing monitored the bowel dashboard daily for	F 684	-Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; weekly for two (2) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 6/30/23	

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F 684	Continued From page 26 bowel movements. The DON stated going forward the standing orders would specify the day to initiate the bowel program Facility policy titled, Bowel Program dated 5/23, indicated: Policy: all residents at Bayside Manor will be monitored for signs and symptoms of Constipation and receive adequate dietary and pharmacological intervention to ensure bowel regularity. Procedure: 1. Staff will first attempt to utilize dietary products available at Bayside Manor as means of promoting a BM. The following are available for use: -prune juice -bran/applesauce/prune juice -fiber care in 1-ounce individual cups (prune and dried fruit mixture) as needed 2. If the above measures are ineffective to relieve constipation staff will use the following: -milk of magnesia 30 CC orally up to BID PRN for constipation (please avoid if on dialysis) if not effective within 24 hours, then: -Senokot one tablet orally up to BID PRN for Constipation if not effective within 24 hours, then: -Bisacodyl Suppository 10 milligrams rectally PRN for Constipation. 3. If the above laxatives/suppositories are used x 1 week contact the residents MD for order. Any other interventions will require physician contact and order	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		6/30/23

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F 686	Continued From page 27 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the skin for pressure ulcer (PU) for 1 of 1 resident (R21) who was diagnosed with pressure ulcer following a re-admission from the hospital. Findings include: R21's face sheet printed 5/11/23, included diagnosis of fracture of neck of left femur, pulmonary fibrosis (lung tissue scars, thickens and stiffens), fracture of left pubis (pelvic bone), multiple fractures of ribs right side, heart failure, dementia, neoplasm (abnormal growth of tissue) of left kidney, and repeated falls. R21's significant change Minimum Data Set (MDS) dated 2/8/23, indicated severe cognitive impairment, and delirium which included inattententiveness that comes and goes. Activities of daily living (ADL's) included extensive assist of 2 persons for transfers, bed mobility, personal hygiene and toileting. R21 was at risk for	F 686	F686 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate	

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F 686	Continued From page 28 pressure ulcers but had no skin issues currently. R21's current care plan dated 2/2/23, last revised 3/23, indicated impairment to skin integrity related to immobility with coccyx wound related to advanced age, terminal illness and fragile skin. Interventions included: turn and reposition every 2-3 hours, encourage good nutrition and hydration in order to promote healthier skin, identify/document potential causative factors and eliminate/resolve where possible. Follow facility protocols for treatment of injury. An Incident Review and Analysis form dated 1/29/23 at approximately 2:30 a.m., indicated R21 was found on the floor in her bathroom on her left side and back. R21 was transferred to the emergency department (ED) via ambulance and admitted with diagnosis of left femur fracture. R21 returned to the facility on 2/2/23, with hospice services. A hospital discharge summary dated 2/2/23, indicated principal diagnosis of fracture of neck of femur with active problems listed as renal mass, heart failure and frequent falls. R21 had surgical intervention on 1/30/23. Recovery was complicated by increased confusion and rapid heart rate. After discussion with the family, hospice services and comfort care was implemented upon discharge. R21's Readmit Data Collection form dated 2/2/23 and completed by licensed practical nurse (LPN)-A at 10:39 a.m., indicated a change in activity level and activities of daily living (ADL) dependencies with Foley catheter in place. Skin assessment included left trochanter (hip) surgical incision intact with 15 staples, face with several	F 686	submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed to ensure residents admitted to the facility have a comprehensive skin assessment completed at the time of admission. -All residents who are admitted to the facility have the potential to be affected if this requirement is not met. - R21 has not discharged or transferred out of the facility. A comprehensive skin assessment has been completed. -All residents have a comprehensive skin assessment completed. -Necessary staff have received education on completing a comprehensive skin assessment upon admission and readmission to the facility. -The facility QAPI team reviewed the CMS-2567 and POC during the June 2023 meeting. -Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; weekly for two (2) weeks; and monthly thereafter for one (1) month. Audit results will be	

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F 686	Continued From page 29 areas of bruising related to fall and bilateral arms with several bruises noted. The Readmit Data Collection form lacked evidence of deep tissue injury. Further, the record lacked evidence a comprehsive skin assessment was completed at time of re-admission. A progress note dated 2/7/23, by medical provider (MP)-L, indicated R21 had left hip fracture with surgical repair on 1/30/23. R21 experienced significant delirium post-op and was enrolled in hospice upon return back to the facility on 2/2/23. R21 had been lethargic and sleeping most of the time. R21 had no rashes, wounds or lesions to exposed skin. Has extensive facial bruising, left hip incision with no redness or drainage. Anticipate progressive decline with comfort focused care. R21's weekly skin inspection on 2/8/23, by registered nurse (RN)-A removed a mepliex from the coccyx area and noted a blister on left buttock, 2.0 x 2.6 cm, with abrasion on left lower buttock 1.5 x 1.5 cm. Unstageable purple area 5.1 x 2.6 cm on coccyx (most distal portion of the spine). Left lateral buttock has a 2.6 x 1.0 cm intact blister. Right buttock had an area of discoloration 1.0 x 1.2 cm. A wound care consult dated 2/14/23, medical provider (MP)-M indicated deep tissue pressure injury to coccyx. Wound likely to continue to evolve. Pressure relief/off loading per facility protocol. A weekly wound evaluation form dated 2/15/23, LPN-A indicated coccyx with a deep tissue injury 9 cm by 7 cm. Description of wound included area will likely continue to evolve. Scant amount	F 686	reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 6/30/23	

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F 686	Continued From page 30	F 686		

of serosanguious (pale red made of serum and red blood cells typically seen as wound is trying to heal) drainage noted.

Wound evaluation form dated 2/17/23, LPN-A indicated coccyx with pressure wound, unstageable 6 x 4 x 0.2 depth with 100% slough (layer of dead tissue) present. Description included wound bed was grayish slough with noted yellowish slough around edges. Moist in appearance. Provider was updated with new orders for wound care. MP-M to place calcium alginate silver to wound bed and cover with silicone foam border dressing three times a week and as needed.

A wound care consultant progress note dated 2/21/23, MP-M indicated coccyx pressure ulcer deteriorating 11 x 8 x 0 with light serosanguinous drainage.

Wound evaluation form dated 2/22/23, LPN-A indicated unstageable coccyx wound 11 x 8 x 0 with wound bed 100% necrotic with light serosanguinous drainage.

A wound evaluation dated 3/6/23, by MP-M indicated stage 4 coccyx pressure ulcer, improving. Wound is 9 x 7 x 0.8 27 with undermining present. Heavy serosanguinour drainage. 35% necrotic tissue and 65% granulation. No bone visible. Wound is almost free of slough, necrotic tissue. Does expose muscle/fascia level.

Wound evaluations and measurements continued weekly by counsulting wound MP-M and LPN-A with wound improving.

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Most recent consulting wound care progress note dated 5/4/23, MP-M indicated hospice services remain in place. Follow up management of deep tissue injury evolved to stage 4 pressure ulcer. Wound was improving with measurements of 3 x 0.7 x 1.2. Moderate serosanguinous drainage continued with 100% granulation with muscle exposed but no bone. Wound continued to improve week over week.

Most recent wound evaluation 5/5/23, LPN-A indicated a stage 4 pressure ulcer on coccyx 3 x 0.7 x 0.3 with 100% granulation. Wound was healing, no bone exposure with minimal drainage and no pain noted. Current intervention include cleanse with Vashe wound cleanser. Moisten gauze and allow to remain on wound bed for 3-5 minutes with each dressing change. Apply skin prep to wound edges. Pack wound with silver calcium alginate. Cover with silicone foam border dressing. Change three times per week and as needed.

A Braden Scale (measures elements of risk for development of pressure ulcers) was completed 5/8/23. R21 was identified as high risk.

Observation 5/9/23, R21 was in her chair in the dining room for music. Cushion was present in wheelchair.

Observation and interview on 5/9/23 at 1:59 p.m., R21 did not respond to questions. R21 was lying in bed on her left side with air mattress present on the bed.

Observation on 5/10/23 at 3:00 p.m., R21 was taken back to her room after attending activity and was transferred to her bed and was lying on

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F 686	Continued From page 32 her left side. Observation on 5/10/23, at 4:43 p.m. R21 was hollering out for help and began to climb out of bed. The director of nursing (DON) and nursing assistant (NA) responded immediately and R21 was transferred back to her chair and out to the common room. R21 remained in wheelchair in common room until 6:15 p.m. when an aide assisted R21 back to her room, checked and changed and settled into bed on her right side. Interview on 5/10/23, at 3:30 p.m., LPN-A stated she assessed the wounds she could visualize upon return and assumed the nursing staff would do a complete skin check upon admission. LPN-A confirmed she did not observe the coccyx area upon return so was unsure if deep tissue injury was present on admission or not. Interview on 5/11/23, at 10:20 a.m., NA-C indicated she doesn't remember if R21 was admitted with a sore on her coccyx or if a dressing was present. NA-C added they were repositioning her every 1-2 hours when she initially returned. Now they are doing at least every 2 hours. Interview on 5/11/23, at 10:40 a.m., NA-B indicated she wasn't sure if R21 had a sore on her coccyx or dressing present when she returned from the hospital. NA-B added she normally worked night shift and they were repositioning R21 every 1-2 hours. During interview on 5/11/23 at 11:10 a.m., the DON indicated she expected a full head to toe skin inspection upon readmission to the facility. She confirmed one was not completed for R12	F 686		

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F 686	Continued From page 33 upon re-admission. Interview on 5/11/23, at 3:53 p.m., with hospice registered nurse (RN)-B indicated she was not the admission nurse for R21. RN-B reviewed R21's record and indicated on 2/2/23 admission documentation there was no coccyx wound documentation present but facial areas with bruise, surgical incision on hip was present. Documentation included important to reposition every two hours and an air mattress was ordered on admission. Interview on 5/12/23 at 8:29 a.m., MP-L indicated she was not sure if the resident was admitted with the wound present or if it occurred after admission. MP-L added given R21's health and the health condition she returned in, it was difficult to say if the wound began in the hospital or at the facility or if it was preventable. MP-L added staff were repositioning R21 every 1-2 hours and the family was always present advocating for repositioning. A Skin Assessment and Wound Management policy and procedure dated 5/27/22 included: -A pressure ulcer risk assessment will be completed for every resident upon admission (Braden Scale). -Staff will perform routine skin inspections with daily care. -Nurses are to be notified if skin changes are identified. -A weekly skin inspection will be completed by licensed staff.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		6/30/23

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F 688	Continued From page 34 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure staff provided walking program to meet the assessed needs for 1 of 1 residents (R12) reviewed for restorative services. Findings include: R12's face sheet printed on 5/11/23, indicated diagnoses of cerebrovascular disease (conditions that impact the blood vessels in the brain) with dsyarthria (speech disorder cause by paralysis or weakness of the muscles of the mouth) and hemiplegia and hemiparesis (paralysis), type 2 diabetes mellitus with neuropathy (nerve damage) and weakness. R12's significant change Minimum Data Set (MDS) assessment dated 3/22/23, indicated	F 688	F688 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and	

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moderate cognitive deficit, no behaviors including rejection of care and extensive assist of one for dressing, personal hygiene, toileting and transfers. Walking on and off unit did not occur.

R12's care plan dated 4/3/23, indicated an activities of daily living (ADL) performance deficit and required minimal assist of 1 with gait belt and walker for transfers, moderate assist of 1 for ambulation. R12 was to ambulate 2 times daily with gait belt and front wheel walker with wheelchair to follow behind (2 people). Support the right hand on the 4 wheeled walker.

During interview on 5/8/23 at 9:42 a.m., R12 stated when she first got to the facility she could walk with one foot, but now she was to weak. R12 stated she would like to walk in the hallway but staff don't take her for a walk. R12 added she was currently in therapy related to weakness from a recent Covid-19 infection.

Interview on 5/8/23 at 2:31 p.m., family member (FM)-C stated staff were not walking R12 as her legs were to weak and staff had indicated it wasn't safe.

During observation on 5/10/23 at 1:13 p.m., R12 was in her wheelchair and used one leg to wheel herself to the dining room.

Observation on 5/10/23 at 4:06 p.m., R12 was in her wheelchair in her room. R12 stated therapy did not work with her today and no staff had walked her.

During observation on 5/10/23 at 6:20 p.m., R12 was in the dining room and wheeled self back to her room and into the bathroom. R12 came out of

submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility’s credible allegation of compliance.

-The process for satisfying this requirement has been reviewed and revised as needed to ensure residents who require a restorative program has been developed and is being carried out by staff.

-All residents in the facility have the potential to be affected if this requirement is not met.

- R12 is currently in therapy and an ambulation program is in the process of being developed with Physical therapy.

-All residents that are in Occupational, Physical and Speech therapy will have a restorative program developed if indicated and staff will carry out restorative program as appropriate.

- NAR guides for all residents who have restorative programs in place have been reviewed to ensure there are clear instructions on how to carry out the restorative program.

-Necessary staff have received education

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the bathroom a few minutes later and was sitting in her room in her wheelchair. At 7:17 p.m., staff entered room, assisted R12 into her pajamas, and then watched television from her wheelchair.

Interview on 5/10/23 at 1:53 p.m., FM-D stated R12 was currently in therapy because staff "never ask her to walk at all". FM-D added she was at the facility all day and had "never once seen staff walk R12" even though therapy had recommended it in the past. FM-D stated R12 also told her staff do not walk her.

A progress note dated 3/2/23 at 5:14 p.m., licensed practical nurse (LPN)-A indicated recommendations from therapy were received and directed: Bed mobility, minimal assist of one. Transfers, minimal assist of 1 with gait belt and walker. Ambulation, assist of one with use of gait belt and front wheeled walker (FWW) with wheelchair to follow, to tolerance. Remind to stand tall and support right hand on FWW.

A Therapy Transfer Recommendations form dated 3/2/23, indicated ambulation to occur two times per day with assist of 1, wheelchair to follow with second person, gait belt and front wheeled walker to tolerance and remind to stand tall, support right hand on FWW.

A Physical Therapy Discharge Note dated 3/14/23, physical therapist (PT)-B indicated R12 was at baseline on 2/6/23. R12 ambulated upwards of 50 feet with FWW and contact guard assist with cues and difficulty with turns. At discharge on 3/14/23, R12 was inconsistent with distances which was dependent on blood glucose levels and fatigue. Discharge recommendations included a walking program with caregivers,

on the process for communication from therapy to nursing of restorative programs when one is developed.

-Necessary staff have been educated on the expectations of carrying out restorative programs as developed by therapy.

-The facility QAPI team reviewed the CMS-2567 and POC during the June 2023 meeting.

-Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; weekly for two (2) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence.

-Director of Nursing or designee is responsible party.

-Corrective action will be completed on or before 6/30/23

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Continued From page 37
FWW and wheelchair to follow, with assist of 1 for transfers.

Review of point of care ambulation record from 3/3/23 through 4/16/23, included:
Walk in hallway: Not applicable (NA) 86 times out of possible 90 attempts. Walking occurred 4 times requiring limited to extensive assistance.
Walk in room: NA 87 times out of possible 90 attempts. Walking occurred 3 times requiring limited to extensive assistance.

Interview and observation on 5/11/23 at 8:57 a.m., R12 was in the dining room eating breakfast in her wheelchair. R12 used one leg to wheel self back to her room. R12 stated she wanted to walk more and felt she was in the wheelchair too much. R12 added when she came to the facility she used the walker and now she doesn't at all and was "stuck" in this wheelchair.

During interview on 5/11/23 at 9:04 a.m., NA-C stated they have walked R12 in the past but currently she was working with therapy and were told not to.

Interview on 5/11/23 at 9:06 a.m., physical therapy aide (PTA)-E stated therapy started working with R12 after she had Covid-19 on 4/16/23. PTA-E indicated she was an assist of 2 at that time and was currently in between 1 and 2 assist. PTA-E stated R12 was supposed to be on a walking program prior to this and if staff were not walking her, they should have been.

Interview on 5/11/23 at 10:38 a.m., nursing assistant (NA)-B stated she did not think they were walking R12 at all since she was admitted, she was not on an ambulation program.

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F 688	Continued From page 38 Interview on 5/11/23 at 1:07 p.m., the director of nursing (DON) stated PT left recommendations on the desk and when she saw R12's order sitting there shortly after she started at the facility at the end of March, asked staff what happened next, staff were unsure. The DON stated a new process was put into place that included review by the interdisciplinary team (IDT). IDT evaluated for realistic expectations and then care planned and added to tasks. The DON included her expectation was staff would complete the task and when resident refused, it was reported to either the nurse or her, and documented. A policy and procedure on ambulation was requested and none was received.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to comprehensively assess 1 (R9) of 6 residents reviewed for falls, for safe use of resident equipment, including independent use of an electronic lift chair. The findings include:	F 689	F689 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also	6/30/23

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R9's face sheet printed 5/11/23, indicated diagnoses including, hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (stroke) affecting right dominant side, vascular dementia (problems with reasoning, planning, judgment, memory and thought processes) without behavioral disturbance and long term use of anticoagulants (medication that inhibits coagulation of the blood).

R9's quarterly Minimum Data Set (MDS) dated 4/6/23, included R9 usually understands and is understood, severe cognitive impairment, has had a fall and on an anticoagulant and diuretic. Activities of daily living (ADL's) included extensive assistance of one person for locomotion, personal hygiene, dressing and toileting.

R9's fall risk assessment completed 9/15/21, indicated a fall risk score of 17, high fall risk. The next fall risk evaluation was completed on 5/11/23, which indicated R9 was at a potential risk for falls secondary to functional and cognitive deficits. No falls since 10/8/22. Will continue to monitor resident's safety.

A facility Event Report dated 10/10/22 at 5:09 p.m., indicated R9 had a fall from chair or wheelchair on 10/8/22 at 5:45 a.m. Causal factor for the incident included R9 was sitting in her recliner in her room. Staff heard resident call out for help. When entering resident's room, staff noted the resident was sitting on the floor with her legs straight forward and her upper body was leaning against the foot of the recliner which was extended out. No injuries were noted. Contributing factors included hemiplegia nd hemiparesis following cerebral infarction affecting the right dominant side. Medications included

F 689

not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.

-The process for satisfying this requirement has been reviewed and revised as needed to ensure residents are safely utilizing equipment, including electric lift chairs.

-All residents in the facility who use electric lift chairs have been assessed for safety. All residents who have electric lift chairs in their rooms have been assessed as safe to have.

- R9 has been assessed for safe use of the electric recliner. It was determined she was not safe to use independently, and

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Eliquis (use to prevent serious blood clots from forming). Interventions included Dysem (non slip material) to chair or wheelchair.

R9's plan of care dated 11/10/22, indicated a potential risk for falls characterized by history of falls. Interventions included: analyse previous resident falls to determine whether pattern/trend can be addressed, dycem placed in recliner over soaker pad to help prevent resident from sliding, keep common used articles within reach, transfer to recliner after meals per request and resident to wear proper and nonslip footwear.

R9's care plan dated 4/20/23, indicated at risk for falls related to alteration in mobility and decreased safety awareness related to cognitive impairment. Interventions included: call light to be clipped to gown or on person, check on resident 3-5 times per shift while positive for Covid-19, and follow facility fall protocol.

During interview on 5/8/23 at 11:41 a.m., R9 did not remember any falls at the facility or fall from her electric recliner.

Interview on 5/10/23 at 2:42 p.m., licensed practical nurse (LPN)-A stated R9 was able to run her own chair but for some unknown reason elevated the chair up and it kept going until she slid out of the chair. LPN-A stated she reviewed the record. She was unable to locate a safety assessment with the electric recliner chair and unsure when R9 was last assessed for safety.

Interview on 5/10/23 at 4:58 p.m., social services (SS)-A stated she was contacted by a family member with concerns related to R9 being in a chair early the morning the fall occurred. R9 was

Provider's Plan of Correction (F 689):

the chair has been removed. She has been provided with a non-electric recliner.

- Assessments have been completed for all residents who own electric recliner chairs. All residents who have electric recliners in their rooms have been assessed are safe to utilize. Any resident who was assessed as being unsafe has had the electric recliner removed.

-Necessary staff have received education on the assessment process for electric recliners and the need to complete new assessments upon admission, quarterly, and as needed.

-The facility QAPI team reviewed the CMS-2567 and POC during the June 2023 meeting.

-Audits will be completed weekly for four (4) weeks; Quarterly for two (2) quarters and then annually. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence.

-Director of Nursing or designee is responsible party.

-Corrective action will be completed on or before 6/30/23

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BAYSIDE MANOR LLC	**640 THIRD STREET GAYLORD, MN 55334**

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F 689	Continued From page 41	F 689		

found in front of the recliner and the recliner had been elevated and tipped to the standing position. R9 was not able to recollect the incident. SS-A stated her and (LPN)-A had completed assessments in the past for safety with the use of an electric recliner but upon request was not able to locate when R9 was last assessed.

Interview on 5/11/23 at 1:08 p.m., the director of nursing (DON) stated the facility had an assessment for electric chairs, which should be completed every 3 months for residents who have electric recliners. The DON added she recently reviewed R9's plan of care and discontinued use of the dycem as she felt it was outdated. The DON confirmed the electric chair should have been assessed prior to the fall, immediately after, and quarterly thereafter.

A Fall Prevention and Management policy last revised 2/2021 included:
- After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred, where it occurred and what the individual was trying to do at the time the fall occurred.
-Nursing staff will begin to try to identify possible or likely causes of the incident.
-Staff will evaluate chains of events or circumstances preceding a recent fall, including, time of day, what the resident was doing or attempting to do, whether the resident was standing, walking, reaching or transferring from one position to another. Whether any environmental risk factors were involved (e.g. slippery floor, poor lighting, furniture or objects in the way).
-The interdisciplinary team will review falls daily at morning meeting.

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F 689	Continued From page 42 -The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause can not be found. -Avoidable accident means that the accident occurred because the facility failed to: Identify environmental hazards and or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and or evaluate/analyze the hazards/risks and eliminate them, if possible, or if not possibly, identify and implement measures to reduce the hazards/risks as much as possible. A policy on Electric Lift Chair Recliners dated 12/2019 included: -The facility will make a reasonable effort to identify the potential hazards and risk factors for each resident. -Licensed staff, therapy personnel, and/or the interdisciplinary team, will complete a comprehensive evaluation of the resident's ability to safely use the recliner lift chair. - The residents plan of care will include specific instructions for safe use which could include, but is not limited to, resident's access to controls and position the chair and/or resident should be left in. -Development of alternative safety measures may be necessary if the evaluation determines the recliner chair is unsafe to use. -If the resident cannot operate or use the recliner lift chair safety, the risk versus benefits will be reviewed and documented with the resident and/or resident representative and primary provider as applicable.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		6/30/23

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F 698	Continued From page 43 §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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to have a coordinated plan with ongoing communication for dialysis treatments and obtain a written contract/agreement between the dialysis provider and the facility for 1 of 1 residents (R10) reviewed for dialysis. Findings include: R10's face sheet printed 5/11/23, identified diagnosis of end stage renal disease and type 2 diabetes mellitus with diabetic chronic kidney disease. R10's quarterly Minimum Data Set (MDS) dated 2/8/23, identified R3 received dialysis, had an indwelling catheter and required limited assist of 1 for toilet use. R10's care plan dated 11/2/2019, included the resident needed hemodialysis related to renal failure. Interventions included R10 attended dialysis Monday, Wednesday, and Friday. Run time started at 8:30 a.m. and transportation arrived at 7:50 a.m. Dialysis phone number was listed. On 5/10/23 at 4:32 p.m., the regional operations director (ROD) indicated the facility did not have a contract or agreement with the dialysis center for coordination of services. The ROD also looked	F 698	F698 s/s D Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this	

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under the facilities previous name and no contract was located.

Interview on 5/10/23 at 2:00 p.m., licensed practical nurse (LPN)-C stated the facility sent a communication record with R10 but sometimes the bottom portion was not completed and sent back to the facility with the resident. R10 returned today (5/10/23) without return of the communication form, dialysis run information including vital signs, and pre and post weights.

Interview on 5/10/23 at 2:00 p.m., licensed practical nurse (LPN)-A stated the facility has not had coordinated services or plan of care with the dialysis facility. LPN-A added they (dialysis provider) were not good at communicating and the facility needed to call to get the information regarding dialysis treatments.

Interview on 5/10/23 at 2:05 p.m., director of nursing (DON) confirmed the facility lacked coordinated services with the dialysis facility and needed to call to get post dialysis information. The DON stated she became aware after the agreement/contract was requested that there wasn't one.

A policy for Hemodialysis dated 11/22/19, included:
-The facility staff and the dialysis center will have ongoing communication and collaboration regarding dialysis care and services.
-The facility should communicate, facilitate, and coordinate with the dialysis team regarding a plan for preventative skin interventions and toileting needs.
-Transportation to and from the dialysis center will be pre-arranged according to the dialysis contract

F 698

requirement has been reviewed and revised as needed, to ensure there is an agreement in place and a coordinated plan with communication for any resident receiving such services.

- All residents residing in the facility who received dialysis services have the potential to be affected if this requirement is not met.

- Facility will ensure a written dialysis agreement is in place for all residents receiving dialysis.

- The plan of care for R10 was reviewed and revised as needed to ensure there was no harm or lasting effects.

- The facility immediately initiated conversation with the dialysis center and obtained an agreement, which was provided prior to survey exit. This is completed and will not expire unless either party agrees.

- The facility will leverage the completed agreement to ensure communication and collaboration with the dialysis center. Bayside Manor staff have been educated using Monarch Healthcare Management policy and procedure on Hemodialysis.

- Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any

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F 698	Continued From page 45 that has been agreed upon by the facility and dialysis center. -Ongoing communication and collaboration for the development and implementation of the dialysis plan of care should be maintained by the facility and dialysis team. -Communication shared between the facility and dialysis provider can include, but is not limited to the resident's response to the dialysis treatment, medications administered, labs drawn and their results, the resident's end weight, changes in condition or mood, and the evaluation of the access site. -If run information is not received with the resident upon return, facility staff will call the dialysis unit to obtain the information. Problems with obtaining dialysis information will be reported to the DON and/or the medical director.	F 698	deficient practice corrected at the time of occurrence. - DON or designee is responsible party. - Corrective action will be completed on or before 6/30/23	
F 725 SS=F	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	F 725		6/30/23

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resident care plans:
(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 observation, interview, and document review the facility failed to provide sufficient staffing to ensure residents received care and assistance as needed. These deficient practices had the potential to affect all 33 residents who resided in the facility.

Findings include:

R5's quarterly Minimum Data Set (MDS) dated 3/14/23, indicated severe cognitive impairment, required two-person physical assist with bed mobility, transfer, dressing, toilet use, and one person physical assist with personal hygiene, utilized a wheelchair and diagnoses included: heart failure, seizure disorder, anxiety disorder, depression, and Alzheimer's disease.

R8's quarterly MDS dated 4/18/20/23, indicated severe cognitive impairment, required one-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair, no rejected care behaviors and diagnoses included: pulmonary fibrosis (lung disease that causes lung tissue to scar, thicken, and stiffen), Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic

F 725

F725 s/s E:

Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is

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claudication (spinal nerves get compressed in the lower spine, osteoarthritis of hips, depression, dementia.

R8's care plan dated on 4/7/23, indicated an ADL self-care performance deficit r/t (related to) pulmonary fibrosis, Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication, osteoarthritis of hips, depression, dementia; interventions included dressing, grooming, bathing, eating, extensive A1 (assist of one); shower/bath Wednesday AM hospice, Saturday PM NAR (nursing assistant),

R13's quarterly MDS dated 4/25/20/23, indicated intact cognition, required two-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair and diagnoses included: heart failure and osteoarthritis of the right hip.

R13's care plan dated 1/30/23, indicated alteration in ADL status r/t (related to) neoplasm of bladder (bladder cancer), CHF, Afib, arthritis in hip and weakness dressing, grooming, bathing extensive A1 (assist of one),resident has own teeth; set up and assist with oral cares in AM and before bed; frequently incontinent of bowel and bladder r/t diuretic use, alteration in mobility and malignant neoplasm to bladder, toilet on demand, upon arising, mid am/pm, before/after meals and at hs (bedtime), check/change on NOC (night) rounds.

R17's quarterly MDS dated 4/28/23, indicated intact cognition, required one-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair and walker and diagnoses included:

F 725

submitted as the facility's credible allegation of compliance.

-The process for satisfying this requirement has been reviewed and revised as needed to ensure residents receive care and assistance as needed.

-All residents in the facility have the potential to be affected if this requirement is not met.

-The schedule is reviewed daily by DON or designee, Scheduler, and/or Administrator or designee, to ensure staffing levels continue to be appropriate pursuant to Minnesota Administrative Rules 4658.0510 - Nursing Personnel. Staffing is tracked and audited daily utilizing direct care per patient day ratios (HPPD) via the payroll software and is compared against local, state, and federal standards; as found on the CMS Nursing Home Compare website and Monarch Healthcare Management intranet. CMS Payroll Based Journal (PBJ) reports will continue to demonstrate past, present, and future compliance.

-Those educated, using Monarch Healthcare Management "Open shift staff policy", included but was not limited to, Administrator, DON, and Scheduler.

-In an effort to fill all vacancies, the facility will continue with recruitment and retention efforts to hire and retain their own staff.

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polyosteoarthritis, personal history of transient ischemic attack (stroke like attack), history of falling, and glaucoma (increased pressure within the eyeball, causing gradual loss of sight).

R17's care plan dated 5/3/23, indicated and ADL self-care performance deficit; interventions included dressing, grooming, bathing extensive A1 (assist of one), shower/bath Monday am around 6:30 a.m.

R12's face sheet printed on 5/11/23, indicated diagnose included: cerebrovascular disease (conditions that impact the blood vessels in the brain) with dysarthria (speech disorder cause by paralysis or weakness of the muscles of the mouth) and hemiplegia and hemiparesis (paralysis), type 2 diabetes mellitus with neuropathy (nerve damage) and weakness.

R12's significant change MDS assessment dated 3/22/23, indicated moderate cognitive deficit, no behaviors including rejection of care and extensive assist of one for dressing, personal hygiene, toileting and transfers. Walking on and off unit did not occur.

R137's entry MDS dated 5/4/23, indicated admitted on 5/4/23.

On 5/8/23 at 9:48 a.m., R13 was seated in a wheelchair, and indicated staff assistance would take up to an hour or more during the mornings. R13 indicated concerns were brought to facility's attention during her care conference, and further indicated about once or twice a week call lights took one hour to be answered.

On 5/8/23 at 10:02 a.m., R5 was observed in bed

-In an effort to fill all vacancies, the facility will continue to contract with External Staffing agencies, as defined by the MN Supplemental Nursing Services Agency (SNSA), and Monarch Healthcare Management float pool for temporary staffing needs.

-In an effort to fill all vacancies, the facility will continue to offer “bonuses” or monetary incentives to potentially assist with additional shifts being picked up by current staff.

-Staffing will be monitored daily to ensure adequate staffing is achieved to meet the needs of all residents.

- The facility risk assessment will be reviewed and revised as needed to reflect the current needs of the facility.

-Audits include, but are not limited to, both resident and staff interviews, and monitoring call light response time(s) via the electronic call light system.

-Audits will be completed five (5) times per week for two (2) weeks; three (3) times per week for 4 weeks; weekly for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence.

-Director of Nursing or designee is responsible party.

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and NA-C indicated staff had not provided R5 with morning cares or breakfast due to the shortage of staff.

On 5/8/23 at 10:26 a.m., NA-C assisted R5 in the wheelchair through the hallway to the dining room. NA-C stated R5 was going to breakfast, and ADLs were just completed due to shortage of staff. NA-C further stated R5 was not assisted until now as R5 was a two person assist. NA-C confirmed R5 had not requested to sleep until now, and further verified other residents were still in bed due to shortage of staff.

On 5/8/23 at 10:39 a.m., R137 stated staff were untimely with call light response and had waited up to two hours for staff assistance. R137 stated the facility was short staff since her admission on 5/4/23.

On 5/8/23 at 11:29 a.m., R137 indicated staff had not offered or provided morning assist until now and indicated preferred to rise and eat breakfast at 6:00 a.m.

On 5/8/23 at 1:39 p.m., R8 stated, at times, waited for an hour or more for the call lights to be answered. Staff entered the room, turned the call light off, and would not assist with what she needed.

During resident council meeting on 5/9/23 at 1:30 p.m., R11 voiced concerns regarding staffing of the facility and long wait times for call lights to be answered. R20, R33, R7, R13, R2, and R17 all voiced agreement. R11 stated she had filed grievances in the past but quit because "nothing will ever change" and "no one ever listens". R11 added they don't have enough staff and run with 2

-Corrective action will be completed on or before 6/30/23.

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staff frequently which has gotten worse over the past 3 months.

On 5/8/23 at 2:31 p.m., during an interview nurse aide (NA)-A stated the facility was short one nursing assistant (NA) today on the day shift, until she arrived at 12:00 p.m. NA-A added yesterday 5/7/23, the facility only had 2 NA's also. NA-A indicated all the residents except R15 were up and dressed for the day when she arrived. NA-A indicated there are 4 residents who require assistance and supervision with eating who were not attended to until she arrived in the dining room around 12:30 p.m. NA-A indicated she called for assistance but no one else arrived to help so she did the best she could. (See F550).

Review of Resident Council Meeting minutes response forms included below concerns with staffing and call light response times:
9/22: call light wait times feel too long. State when they call for help they feel that it will be a least 30 minutes before their light is answered. Response from director of nursing (DON) included we are monitoring call light times and working on education with staff.
10/22: Residents feel they wait for their call light to be answered for a long time. Response from DON included reminded to check in on resident when toileted to check when they are done.
11/17/22: Resident are still stating that the call light waits are too long and they are sitting on the toilet way too long waiting for staff. Response from DON included educated staff to be communicating when they have a resident on the toilet to more quickly respond to call light.
2/27/23: When toileting, staff leave and take way too long to come back. Response from DON indicated education given to all nursing staff that

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when toileting residents, ask if they want to sit a bit or if they should wait because the resident just needs a short time.

On 5/10/23 at 10:19 a.m., NA-D stated at times, she would be responsible for 14-15 residents. NA-D stated the facility was short staffed when two nursing assistants were on the day or evening shift and verified she had worked at the facility during with two NA's. NA-D stated the shortage of staff had caused residents bath missed or delayed, delay in call lights answered, extended wait times, and residents breakfast delayed. NA-D stated 4-5 residents on a normal shift waited until 10:00 a.m. for breakfast. NA-D stated the facility had many residents who required two assist with machines for transfers and caused extended wait times for resident's due to the staff shortage. NA-D indicated residents voice concerns about long call light times.

On 5/10/23 at 11:22 a.m., social services (SS)-A confirmed residents brought extended call light and staff shortage concerns to her. She forwarded the concerns to the director of nursing (DON). SS-A indicated call light reports were run and confirmed the facility had extended call light times and would bring the concerns to morning stand up meeting and alerted the director of nursing.

On 5/10/23 at 11:37 a.m., trained medication aide (TMA)-A stated the facility was fully staffed to meet resident needs with three NA's on the day shift. TMA-A stated when two NA's were scheduled, she assisted with resident care and medication pass. TMA-A stated when only 2 NA's were working, residents may miss baths or have

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F 725	Continued From page 52 extended call light times. On 5/10/23 at 11:58 a.m., NA-C stated NA's were required for resident morning cares to be completed timely. Further, the facility had many residents who required two assists with transfers and caused extended wait times. NA-C stated the nurse would turn the call light off, however, resident needs were not assisted. NA-C confirmed on 5/8/23, residents were not assisted timely with breakfast or morning cares, and verified residents were in bed until 12:00 p.m. NA-C stated often residents were not assisted with morning cares until 10:00 a.m. NA-C stated was consistiently mandated for the next shift due to staffing shortage. NA-C stated residents in the facility required staff assist to and from dining, resident cares were rushed due to the shortage of nursing staff and residents did not receive the care needed such as bathing, walking, and call lights answered timely. On 5/10/23 at 1:26 p.m., NA-A stated the schedule was short staffed when the facility did not have three NA's on the day shift and with two NA's, the residents had a delay in call lights answered, and baths might get shifted throughout the week or delayed. NA-A stated 10:00 a.m. was the average time for the last resident assisted to the dining room for breakfast. On 5/10/23 at 02:06 p.m., LPN-C stated three NA's on the day shift was considered fully staffed and 1-2 times per week 2 NA's were scheduled. LPN-C stated when 2 NA's were scheduled, resident baths were missed or pushed to a different day. Nursing staff helped answer call lights and asked the resident to wait for a NA.	F 725		

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During interview on 5/10/23 at 3:08 p.m., the director of nursing (DON) stated they recently hired a staffing person but until then the administrator was completing the staffing schedules. The staffing employee and administrator were not available for interview. The star system was started on February 15th which included a star placed by a staff person's name so if someone called in, that person was mandated to stay for the first part of the next shift and the evening person with a star by their name was mandated to come in early. Staffing was based on casemix and when residents had a higher level of care staffing was adjusted up. The DON stated expectations for answering call lights was within 15 to 20 minutes. The DON added they were working on call light times currently and recently educated staff on call light answering expectations. The DON stated they do not run a shift with 2 NA's on day or evening shift very often. When it happened, baths might not be done until later in the afternoon but they were still completed. The DON stated the facility was taking admissions but was very particular and choose only low acuity residents to admit to the facility.

During interview on 5/10/23 at 5:25 p.m., TMA-B stated she started at the facility about 5 or 6 weeks ago and on her 4th day at the facility she was left alone on the floor with no other NA's in the building. TMA-B stated that hasn't happened since but there should be three NA's on day and evening shifts. There had been multiple times with only 2 NA's for the shift.

On 5/11/23 at 9:22 a.m., the DON stated the star system was implemented to assist with staffing schedule, and stated starred staff were expected

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F 725	Continued From page 54	F 725		

to stay late or come in early for their scheduled shift. The DON confirmed the implementation of the star system was inconsistent and not always utilized. She verified some days the facility was short staffed due to the star system not implemented or staff not being able to stay past their scheduled shift. The DON indicated residents care with baths, dining delay, extended call light times were a concern with staff shortage. The DON confirmed two NA's was not adequate for the day shift. The DON confirmed with two NA's on the day or evening shift the needs of the residents would not always be met. The DON stated the day shift on 5/8/23, no nurse was nurse scheduled and the DON indicated she worked to cover the nurse shortage. The DON stated she expected call lights answered within 10-15 minutes. The DON indicated she was not aware residents missed baths due to the staff shortage.

On 5/11/23 at 10:37 a.m., NA-B stated her shift was supposed to end at 6:30 a.m. however, was mandated and stayed past her scheduled shift as someone did not show. NA-B stated R15's morning cares were not provided yet and would expect R15 was assisted with morning cares and provided breakfast already. NA- B stated the facility had extended call light times, residents missed or had a delay with showers, or the preference of showers was not given due staffing.

The Facility Assessment dated 9/1/2022, indicated average daily census of 28-33 residents. Daily staffing levels were determined by the daily census and resident acuity levels. Staffing was reviewed daily by the scheduler, DON, and administrator to ensure the staffing level supported resident centered care needs.

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Daily average staffing included registered nurse leadership, 1-2 in AM; Licensed nurses providing direct care; 1-2 in AM, 1-2 PM, and 1 nights. Nurse's aides; 2-3 in AM, 2-3 PM, and 1-2 nights. Trained medication assistant; 0-1 AM, 0-1 PM and 0 on nights.

Review of the facility's staffing schedules for February 15, 2023 through May 2023, revealed an average census of 33-34 residents. The schedules identified 3 NA's on day and evening shifts, but 2 scheduled for night shifts. The schedules lacked required nursing assistants for the following:
February 16th through 28th:
2/16/23 - 1 shift,
2/28/23 - 5 hours on day shift.
March 2023:
3/2/23 - 2 shifts,
3/7/23 - 1 shift,
3/9/23 - 1 shift,
3/10/23 - 1 shift,
3/11/23 - 1 shift plus 5 hours on other shifts,
3/17/23 - 1 shift,
3/20/23 - 1 shift,
3/21/23 - 1 shift,
3/26/23 - 1 shift,
3/27/23 - 2 shifts,
3/28/23 - 5 hours,
3/29/23 - 1 shift,
3/30/23 - 1 shift.
April 2023:
4/4/23 - 1 shift,
4/9/23 - 1 shift,
4/10/23 - 1 shift,
4/13/23 - 1 shift,
4/14/23 - 1 shift,
4/19/23 - 1 shift,
4/22/23 - 1 shift

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F 725	Continued From page 56 4/23/23 - 1 shift 4/24/23 - 3 hours. May 2023: 5/3/23 - 1 shift, 5/4/23 - 1 shift, 5/5/23 - 1 shift, 5/7/23 - 2 shifts, plus 3 hours. Facility call light response logs revealed numerous occasions of longer than 15 minutes wait times. The following were examples of the long wait times. These included but were not limited to the following: 3/1/23 - 5/8//23: R12's longest wait times included: 15 minutes, 29 minutes , 15 minutes, 25 minutes, 32 minutes, 21 minutes, 18 minutes, 24 minutes, 54 minutes, 24 minutes, 18 minutes, 26 minutes, 20 minutes, 30 minutes, 24 minutes, 38 minutes, 27 minutes, 17 minutes, 36 minutes, 42 minutes, 21 minutes, 42 minutes, 34 minutes, 21 minutes, 16 minutes, 19 minutes and 30 minutes. 3/13/23-5/9/23: R8's longest wait times were 34 minutes, 18 minutes, 22 minutes, 33 minutes, 21 minutes, 1 hour 26 minutes, 30 minutes, 30 minutes, 18 minutes. 3/9/23-5/9/23 R13's longest wait times were 17 minutes, 19 minutes, 20 minutes, 38 minutes, 21 minutes, 23 minutes, 28 minutes, 22 minutes, 26 minutes, 32 minutes, 31 minutes, 29 minutes, 27 minutes, 43 minutes, 48 minutes, 36 minutes, 37 minutes, 23 minutes, 42 minutes, 34 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 39 minutes, 55 minutes. 4/9/23-5/8/23: R5's longest wait times were 19 minutes, 28 minutes, 20 minutes, 17 minutes, 15 minutes.	F 725		

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F 725	Continued From page 57 4/16/23-5/9/23: R17's longest wait times were 17 minutes, 22 minutes, 46 minutes, 40 minutes, 3 hours 40 minutes, 36 minutes, 32 minutes, 22 minutes, 25 minutes, 27 minutes, 22 minutes, 39 minutes, 2 hours and minute. 5/5/23-5/8/23: R137's longest wait times included: 19 minutes, 43 minutes, 36 minutes, 33 minutes, 52 minutes, 1 hour and 45 minutes, 50 minutes. Facility's Staffing policy and procedure, undated, included: - Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. -Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. -Staff numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. -Inquiries or concerns relative to our facility's staffing should be directed to the administrator or his/her designee. Facility's policy and procedure Open Shift Staffing Policy dated 2/22/16, included: -In order to ensure the safety and quality of care for all residents, it is the policy to consistently maintain staffing levels that are at or above the government mandates. Therefore when there are open shifts for any reason on the licensed nursing or nursing assistant schedule, the facility will make every effort to fill the open shifts	F 725		

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F 725	Continued From page 58 -Open shifts at the time the schedule is posted or occurring after the schedule is posted in the licensed nursing or nursing assistant department shall be filled by requesting employees to fill such vacancies on a voluntary basis. If a replacement is not found, the following open shift staffing procedure will be utilized -Posted schedules shall designate by an * the individual(s) on each shift who will be expected to cover an open shift after all efforts to fill a vacancy have been exhausted. Employees designated in the shift immediately preceding and following an open shift will be expected to cover 4 hours of the open shift. However, if open shifts occur both prior and after a designated employee's shift, such employee will not be required to cover both shifts.	F 725		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		6/30/23

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F 812	Continued From page 59 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishwashing sanitization was appropriately monitored and failed to ensure storage of food brought in for, or by residents, was safe for consumption. This had the potential to effect all residents in the facility. Findings include: UNLABELED AND UNDATED FOOD On 5/8/23 at 9:15 a.m., a refrigerator in a kitchenette located in the dining room accessible to residents, family and visitors who brought food in from outside the facility was inspected. Food and beverages observed in this refrigerator included the following: 1. Thick it advantage for coffee, opened, undated and labeled expired 1/21/24. 2. Lyon prune juice opened and undated, 3/4 empty with expiration date of 8/23. 3. 1 storage bowl that contained corn on the cob that appeared shriveled, undated and unlabeled. 4. 1 storage bowl that contained a shrimp salad, undated and unlabeled. 5. A chocolate pudding dessert on a cookie sheet 3/4 empty covered with tin foil unlabeled and undated. 6. 2 salad dressing bottles undated and unlabeled 1/2 empty. No expiration present. Multiple other beverages unopened were present. During interview on 5/9/23 at 11:01 a.m., cook (C)-A indicated the refrigerator was for residents only. Residents were to date and label the food they put in there. C-A was unsure who monitored	F 812	F812 s/s F Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed, to ensure dishwasher sanitization is appropriately monitored and food brought in for, or by residents is stored and labeled appropriately.	

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F 812 Continued From page 60
the refrigerator.

On 5/9/23 at 7:33 a.m., opened, undated and expired foods listed above remained in the kitchenette refrigerator.

Interview on 5/11/23 at 9:35 a.m., C-B stated the refrigerator in the dining room was cleaned out today and items not labeled or dated were discarded including the 2 storage bowl containers. C-B confirmed beverages for meals were stored in the refrigerator along with residents foods. C-B confirmed all resident foods should be labeled with resident name and dated. All facility products were labeled with date opened. If unlabled or undated, should be discarded.

A facility policy and procedure for Food brought into a Monarch Healthcare Management Facility dated 4/97 included:
-Purpose is to provide each resident with safe, nutritious, healthy food products.
-If a resident's family's should bring in food for their loved one, and this food can be stored in a sanitary manner in the resident's room, staff will accept this and monitor the use.

DISHWASHER:
On 5/8/23 at 8:39 a.m., during initial tour of the kitchen and dishwashing area, C-B indicated the dishwasher was a chemical dishwasher which was rented. The rental company supplied the products and checked the machine.

Observation and interview on 5/9/23 at 10:39 a.m., C-C ran dirty dishes through the dishwasher. C-C stated it was a low temperature dishwasher but she did not check the dishwasher

F 812

- All residents residing in the facility have the potential to be affected if this requirement is not met.

- The policy and procedures necessary to meet these requirements were reviewed and revised as needed to ensure food is appropriately labeled and staff are aware of the equipment being used and how to use it.

- Education for necessary Bayside Manor staff has been initiated utilizing Monarch Healthcare Management policy and procedures.

- Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence.

- Culinary Director or designee is responsible party.

- Corrective action will be completed on or before 6/30/23.

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F 812	Continued From page 61 with any chemical strips. A clip board hung on the opposite wall that included a Dishmachine Temperature Log (Low temperature). It included a column for wash temperature 120-140 degrees Fahrenheit (F) and Chlorine PPM (parts per million) 50-100. C-C stated they documented the temperature of the wash and rinse cycles and documented results on that form. C-C added she had a hard time seeing the temperature gauge. Next to the clip board was a container labeled Chlorine Strips. C-C stated she did not know what they were for and the last time she tried to use them on dishwasher, the strip remained white. C-C then went into another room and brought out PH (a figure expressing the acidity or alkalinity of a solution) strips and attempted to check dishwasher PH which turned the strip white (no reading). C-C attempted the chlorine strips which turned a blue color indicting 50 PPM of chlorine. During interview on 5/9/23 at 10:50 a.m., C-A indicated the rinse 50-100 PPM chlorine column on the Dishmachine Temperature Log was the rinse temperature. C-A got PH Paper and attempted testing dishwasher which turned the PH paper white (not an actual reading). When shown the chlorine strips, C-A stated she had not been using them. Interview on 5/9/23 at 12:55 p.m., C-B indicated he was not aware of the chemical strips and the dishwasher needed to be tested. Behind the Dishmachine Temperature Log was a policy and procedure titled Dishwasher which included checking the temperature to insure wash water was 150-160 degrees Fahrenheit (F) and rinse water was 180 degrees F. Record temperature per policy of the facility. C-B indicated it needed to be changed to the chemical dishwasher policy	F 812		

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F 812	Continued From page 62 and procedure. Interview on 5/11/23 at 9:35 a.m., C-B stated the proper policy and procedure for dishwasher low temperature (chemical sanitization) was located. Staff needed to be properly educated on the procedure today. A policy and procedure titled Sanitization last revised October 2008 included: - High temperature dishwasher wash temperature 150-165 degrees F for at least 45 seconds with rinse temperature 165-180 degrees for a least 12 seconds. -Low temperature dishwasher (chemical sanitization) wash temperature 120 degrees F and final rinse with 50 PPM chlorine for a least 10 seconds.	F 812		
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet	F 836		6/30/23

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F 836	Continued From page 63 the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to be in compliance with the supplemental nursing service agency (SNSA) requirements; the facility obtained nursing services from Midwest Clinical Resources (MCR), an SNSA, which was not was registered with the commissioner as required per MN State Statute § 144A.71 Subdivision 1. This had the potential to affect all 33 residents who received services from the supplemental staff. Findings include: Review of staff schedules dated 5/5/23 through 5/11/23,verified Shifty Key provided supplemental registered nurse staffing to the facility. During an interview on 5/8/23 at 12:22 p.m., the administrator confirmed Shifty Key did not register with the Minnesota Department of Health's (MDH) SNSA registry.	F 836	F836 s/s D Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING ______ B. WING ______	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE MANOR LLC	640 THIRD STREET GAYLORD, MN 55334

(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 836	Continued From page 64 A policy on agency staffing was not received.	F 836	under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed, to ensure any supplemental nursing service agency (SNSA) is on the approved SNSA list prior to use. - All residents residing in the facility have the potential to be affected if this requirement is not met. - The facility process has been reviewed and revised as needed to ensure that all agencies are on the SNSA prior to signing a contract and periodically reviewed to ensure compliance. - The facility Administrator and Director of Nursing have been trained to this requirement. - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. - Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Administrator or designee is responsible party.	

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F 836	Continued From page 65	F 836	- Corrective action will be completed on or before 6/30/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/10/2023**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/10/2023. At the time of this survey, Bayside Manor, LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/10/2023**

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Bayside Manor LLC was constructed in 1974, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. In 2008, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire

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K 000	Continued From page 2 department notification. The facility has a capacity of 42 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 711 SS=C	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a complete Fire Emergency Plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2 (3). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/10/2023 at 10:00 AM, it was revealed by a review of available documentation that the Fire	K 711	K711 s/s C Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed	6/30/23

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K 711	Continued From page 3 Emergency Plan did not contain the verbiage of staff shall immediately call 911 to report a fire emergency within the facility. An interview with Maintenance Supervisor verified this deficient finding at the time of discovery.	K 711	in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed to ensure that the Fire Emergency Plan did not contain the verbiage of staff shall immediately call 911 to report a fire emergency within the facility. -All occupants of the facility have the potential to be affected if this requirement is not met. -The Fire Emergency Plan verbiage has been updated and reflects the staff shall immediately call 911 to report a fire emergency within the facility. -The Maintenance Director or designee is responsible party.	

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K 711	Continued From page 4	K 711	-Corrective action will be completed on or before 6/30/23.	
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		6/30/23

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K 918	Continued From page 5 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a reliable power transfer to the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.1, and 6.4.3.1 and NFPA 110 (2010 edition), Table 4.1(b). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/10/2023 at 10:15 AM, it was revealed that during the monthly emergency generator test conducted on 02/09/23 it was noted that it took 20 seconds to transfer power from normal to emergency power and during the monthly emergency generator test conducted on 03/23/2023 it was noted that it took 15 seconds to transfer power from normal to emergency power. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 918	K918 s/s C Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility’s credible allegation of compliance. -An area for improvement was identified when, upon document review, there was no evidence to support the facility maintained a reliable power transfer to the emergency generator.	

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K 918	Continued From page 6	K 918	-This has the potential to affect all residents if this requirement is not met. -Maintenance Supervisor has been reeducated to the requirement and the identified area of concern will be corrected immediately. - Audits will be completed weekly for two (2) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. Any deficient practice will be identified and corrected at the time of occurrence. -Audit results will be reviewed at QAPI. Areas of concern will be corrected immediately. -Maintenance Director or designee is responsible party. -Corrective action will be completed by 6/30/23	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced	K 926		6/30/23

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K 926	Continued From page 7 by: Based on a review of available documentation and staff interview, the facility failed to conduct staff training concerned with the application, maintenance and handling of medical gases and cylinders NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/10/2023 at 10:30 AM, it was revealed by a review of available documentation, training documents could not be located to show that staff have been trained with the application, maintenance and handling of medical gases and cylinders. An interview with Maintenance Director and Human Resource Manager verified this deficient finding at the time of discovery.	K 926	K926 s/s F Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed to ensure all necessary Bayside Manor nursing staff are trained in the application, maintenance, and handling of medical gases and cylinders.	

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K 926	Continued From page 8	K 926	-All occupants of the facility have the potential to be affected if this requirement is not met. -Necessary Bayside Manor staff will be educated on the application, maintenance and handling of medical gases and cylinders. Education will be provided using a new course / module in Healthcare Academy. This course is required upon hire, and annually thereafter. -The Human Resource Director will ensure appropriate staff are compliant with online education upon hire and annually thereafter. - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. -The Human Resource Director or designee is responsible party. -Corrective action will be completed on or before 6/30/23.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 13, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

Re: State Nursing Home Licensing Orders
Event ID: BSGS11

Dear Administrator:

The above facility was surveyed on May 8, 2023 through May 11, 2023 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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	00619	A. BUILDING: ______ B. WING ______	C 05/11/2023

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BAYSIDE MANOR LLC	**640 THIRD STREET GAYLORD, MN 55334**

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2 000	Initial Comments	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 5/8/23-5/11/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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	00619	A. BUILDING: ______ B. WING ______	C 05/11/2023

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H54732088C (MN00087517) H54732090C (MN00086351) H54732091C (MN00084339) H54732108C (MN00088066) H54739135C (MN00091604) H54739921C (MN00092249) The following complaints were reviewed. H54732026C (MN00093129 and MN00093241) with a licensing order issued at 0265 H54732031C (MN00090107) with a licensing order issued at 0885 and 0830 H54732089C (MN00086778) with a licensing order issued at 0830, 0900, and 0920. H54732102C (MN00093219) with a licensing order issued at 0265 H54732106C (MN00090098) with a licensing order issued at 0830 H54732107C (MN00090102) with a licensing order issued at 0830 H54732109C (MN00087632) with a licensing order issued at 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	2 000		

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2 000	Continued From page 2 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 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		
2 010	MN Rule 4658.0020 Subp 1 LICENSING IN GENERAL; Required Subpart 1. Required. For the purpose of this chapter, a state license is required for a facility where nursing home care is provided for five or more aged or infirm persons who are not acutely ill.	2 010		6/30/23

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2 010	Continued From page 3	2 010		
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to be in compliance with the supplemental nursing service agency (SNSA) requirements; the facility obtained nursing services from Midwest Clinical Resources (MCR), an SNSA, which was not was registered with the commissioner as required per MN State Statute § 144A.71 Subdivision 1. This had the potential to affect all 33 residents who received services from the supplemental staff. Findings include: Review of staff schedules dated 5/5/23 through 5/11/23,verified Shifty Key provided supplemental registered nurse staffing to the facility. During an interview on 5/8/23 at 12:22 p.m., the administrator confirmed Shifty Key did not register with the Minnesota Department of Health's (MDH) SNSA registry. A policy on agency staffing was not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures regarding utilizing registered SNSA's. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one		Corrected	

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2 010	Continued From page 4 (21) days.	2 010		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths.	2 265		6/30/23

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2 265	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the physician with all available clinical information for a significant physical change for 1 of 1 residents (R136) who was reviewed for notification of change. Findings include: R136's facesheet printed on 5/10/23, indicated admission on 3/4/23 and included diagnoses of surgical aftercare for surgery on the nervous system, discitis (infection of intervertebral disc space), psoas (long muscle in the back) abscess, diabetes, and chronic kidney disease. R136's admission Minimum Data Set (MDS) assessment dated 3/10/23, indicated: R136 was cognitively intact, had adequate vision and hearing, clear speech, could understand and be understood. R136 required extensive assistance of two staff for bed mobility, transfers, and toileting. R136 did not walk. R136's care plan dated 3/4/23 indicated R136 would be free from symptoms of UTI (urinary tract infection). The care plan did not identify potential symptoms of UTI for staff to monitor. Further, the care plan indicated R136 was at risk for alteration in cognition related to diagnoses. R136 was Spanish speaking but knew some English and was his own decision maker. Staff were to document changes in orientation. R136 physician orders included: 3/3/23 - Ceftriaxone, generic name for Rocephin, (treats infections), 2 gm (grams) intravenously daily for psoas abscess, discitis. 3/3/23 - Metformin (anti-diabetic medication)	2 265	Corrected.	

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1000 mg twice a day for hyperglycemia (high blood sugar levels).
3/4/23 - Blood sugars before/after meals and bedtime four times a day for DM (diabetes mellitus).
3/27/23 - Obtain urine sample for UA (urinalysis) related to burning with urination. Fax results to provider.
3/30/23 - UTI progress note every shift for 14 days.
3/30/23 - Levofloxacin (treats infections) 500 mg, one tablet daily for UTI for 14 days.

During record review, the following fax communications indicated:

On 3/26/23 at 6:00 a.m., a Fax indicated the last two nights R136 had a hard time starting flow of urine and pain in the bladder. Only small amount of urine with each attempt using the urinal. (According to nursing progress notes, this fax was sent to medical provider (MP)-I the following day 3/27/23 at 1:58 p.m.). The same day (undetermined time), a fax was received from (MP)-J to check a UA and fax results.

Four days later, on 3/30/23 at 10:11 a.m., a Fax indicated UA results were faxed to MP-I. The same day (undetermined time), a fax was received from MP-J indicating the UA had some [illegible word] findings for infection versus prostatitis. Levofloxacin 500 mg once a day for 14 days was started. R139 was to follow up in clinic if no improvement.

Urinalysis results dated 3/28/23 and 3/29/23 indicated R136's urine had abnormal findings including cloudy urine, positive for blood, ketones (may indicate body is too acidic), protein (a sign kidneys are damaged) and presence of white

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Continued From page 7

blood cells and bacteria. A urine culture (UC) dated 3/31/23 indicated no growth.

Progress notes indicated, nurses documented a sequence of events from 3/26/23 through 3/30/23 in which they informed providers MP-I and MP-J of R136's painful urination, bladder pain and possible urinary retention (difficulty urinating and completely emptying bladder) via fax. However, nursing staff did not communicate other physical changes in R136's condition that had been documented in progress notes, including nausea, back pain, confusion, and hallucinations. Progress notes did not indicate a comprehensive nursing assessment had been conducted to pull together all available information and report it to a provider.

Furthermore, there was delay from the first time R136 reported painful urine to the final UA being resulted. Nursing progress notes indicated the following four-day timeline:
1) 3/26/23 at 5:51 a.m., R136 experienced painful urination and voided a small amount.
2) 3/27/23 at 1:41 p.m., R136 experienced [urinary] frequency and urgency. Message left with MP-I.
3) 3/27/23 at 1:58 p.m., fax to MP-I regarding burning with urination.
4) 3/27/23 at 3:43 p.m., order received from MP-J for UA.
5) 3/27/23 at 3:56 p.m., clinic was contacted for an order for which method to obtain the UA; clean catch or straight cath (catheterization - inserting a tube into bladder).
6) 3/28/23 at 11:03 a.m., 19 hours after the order for the UA was received, an order for a catheterized specimen was received. The specimen was obtained and delivered to the lab (laboratory).

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2 265	Continued From page 8	2 265		

7) 3/29/23 at 1:27 p.m., a call from the lab informed the facility a UC was needed as one had not been ordered with the initial UA order. Another UA would need be obtained in order to do a UC.
8) 3/29/23 at 11:20 p.m., a second UA was obtained.
9) 3/30/23 at 8:18 a.m., the urine specimen was delivered to the clinic lab.
10) 3/30/23 at 12:24 p.m., the UA results were faxed to MP-I and an order was received for an antibiotic.

On 3/31/23 from approximately 12:00 midnight to 3:30 a.m., R136's condition began to deteriorate. R136 experienced a drop in blood sugar to 30 mg/dL (milligram per deciliter), developed 10/10 abdominal pain, low blood pressure of 92/36, elevated pulse of 106 beats per minute, and increased respiratory rate of 36 breaths per minute. During this time, the nursing staff was in contact with the DON and the emergency department (ED) at a nearby hospital. At 3:30 a.m., R136 was transferred to the ED. On 3/31/23 at 11:33 a.m., the facility received a call from the ED at the nearby hospital informing them R136 was septic and in DKA (diabetic ketoacidosis - a diabetes complication where the body produces excess blood acids, or ketones and can be triggered by infection) and would be transferred to a larger hospital. On 3/31/23 at 7:30 p.m., the facility was informed by the larger hospital that R136 had passed away.

During an interview on 5/11/23, at 10:31 a.m., the timeline above from 3/26/23 to 3/30/23 was reviewed with regional nurse consultant (RNC)-H and the director of nursing (DON). RNC-H acknowledged the timeline was accurate. RNC-H acknowledged there was a potential delay in

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treatment for R136. RNC-H stated part of the delay was due to nurses being cautious and wanting the provider to order the preferred method of obtaining the urine specimen - clean catch or straight cath. Further, RNC-H stated the delay was partially attributed to MP-J ordering only a UA on 3/27/23 and not also a UC. The DON who was new to her role during this timeframe, was aware R136 was transferred to the hospital on 3/31/23. However, the DON had not been aware of the clinical changes of confusion and hallucinations R136 experienced in addition to UTI symptoms during the time frame of 3/26/23 to 3/30/23.

During the same interview, RNC-H and the DON stated they would have expected nurses from 3/26/23 to 3/30/23 to have looked at the bigger picture of all symptoms R136 was experiencing - back pain, confusion, and hallucinations, in addition to UTI symptoms, and perform a comprehensive nursing assessment. Following the assessment, contact a provider with the information.

On 5/11/23 at 11:38 a.m., surveyor left a telephone message with clinic triage nurse for MP-I, including purpose of call, R136's name, date of birth, and requested a call back. Triage nurse stated she would forward message to MP-I. Intent of phone call was to discuss timeline from 3/26/23 to 3/30/23 and rapid deterioration on 3/31/23.

During an interview on 5/11/23 at 12:36 p.m., licensed practical nurse (LPN)-A who worked the day shift the week of 3/26/23 to 3/30/23 was not involved in the direct care of R136, but was involved with fax and phone communication between the facility, MP-I and MP-J to obtain the

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UA. LPN-A did not know if nursing staff on duty contacted a provider with the additional symptoms R136 had experienced including nausea, confusion and hallucinations in addition to abdominal pain and painful urination. LPN-A stated with multiple symptoms, she would have expected nursing staff to conduct an assessment, including assessing for bladder distention, possibly requesting an order for a residual urine (the amount of urine remaining in the bladder after urination), assess R136's oral intake against urine output, listen to bowel sounds, assess color and characteristics of R136's urine, assess vital signs, and then contact a provider with that information. LPN-A added, I would inform him what I found and ask if he wanted to initiate anything prior to receiving the UA results. LPN-A did not know why this had not been done.

During an interview on 5/11/23 at 2:35 p.m., RNC-H reaffirmed she would have expected nursing staff to notify a provider as soon as new symptoms were identified the week of 3/26/23 to 3/30/23. RNC-H indicated that upon admission, R136 had elected to keep his personal medical provider, MP-I, rather than utilize the providers who regularly saw residents at the facility. RNC-H stated most communication with MP-I and MP-J were conducted via fax.

On 5/11/23 at 4:44 p.m., surveyor placed a second call to clinic for MP-I. Was informed the earlier message had been given; no need to leave another message. As of 5/15/23 at 4:00 p.m., no return call had been received.

On 5/11/23 at 5:00 p.m., towards the end of the survey, the DON provided paper copies of clinic telephone encounters between MP-J, clinic nurses and nurses at the facility from 3/27/23 to

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3/28/23. The encounters further identified a delay in obtaining and resulting the initial UA. A total of 10 phone calls took place between the facility and the clinic. From the first phone call on 3/27/23 at 1:43 p.m., when the facility called the clinic requesting a UA, to the last phone call on 3/28/23 at 10:37 a.m., with the order for the size urinary catheter to use, a total of 20 hours elapsed. Of those 20 hours, more than 17 hours were from the facility not answering a phone call from the clinic on 3/27/23 at 4:57 p.m., with the order to obtain a straight cath urine specimen. The clinic called back the next morning with that order.

The size urinary catheter was within the scope of practice for a nurse to determine using facility policy and/or textbook or online clinical reference material. In addition, nursing staff failed to organize their thoughts and questions when contacting the provider to request a UA for R136 (whether to obtain a clean catch or straight cath specimen and what size urinary catheter to use). This failure resulted in multiple phone calls and a 20-hour delay. This delay was in addition to the delay incurred when the lab requested a second UA in order to do a UC.

Facility policy titled Change in a Resident's Condition or Status, undated, indicated the facility would promptly notify the physician/health provider of changes in the residents medical condition. The nurse would notify the residents attending physician or physician on-all when there had been a significant change in the residents physical/emotional/mental condition. Prior to notifying the physician or healthcare provider, the nurse would make detailed observations and gather relevant and pertinent information for the provider. Except in medical emergencies, notifications would be made within 24 hours of

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2 265	Continued From page 12 change occurring in the residents medical/mental condition or status. If a significant change in the resident physical or mental condition occurred, a comprehensive assessment of the residents condition would be conducted. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures related to timely notification of resident change in condition to a physician were accurate. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures related to timely notification of change in resident condition. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
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 observation, interview, and document review the facility failed to provide sufficient	2 800	Corrected.	6/30/23

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2 800	Continued From page 13 staffing to ensure residents received care and assistance as needed. These deficient practices had the potential to affect all 33 residents who resided in the facility. Findings include: R5's quarterly Minimum Data Set (MDS) dated 3/14/23, indicated severe cognitive impairment, required two-person physical assist with bed mobility, transfer, dressing, toilet use, and one person physical assist with personal hygiene, utilized a wheelchair and diagnoses included: heart failure, seizure disorder, anxiety disorder, depression, and Alzheimer's disease. R8's quarterly MDS dated 4/18/20/23, indicated severe cognitive impairment, required one-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair, no rejected care behaviors and diagnoses included: pulmonary fibrosis (lung disease that causes lung tissue to scar, thicken, and stiffen), Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication (spinal nerves get compressed in the lower spine, osteoarthritis of hips, depression, dementia. R8's care plan dated on 4/7/23, indicated an ADL self-care performance deficit r/t (related to) pulmonary fibrosis, Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication, osteoarthritis of hips, depression, dementia; interventions included dressing, grooming, bathing, eating, extensive A1 (assist of one); shower/bath Wednesday AM hospice, Saturday PM NAR (nursing assistant), R13's quarterly MDS dated 4/25/20/23, indicated	2 800		

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intact cognition, required two-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair and diagnoses included: heart failure and osteoarthritis of the right hip.

R13's care plan dated 1/30/23, indicated alteration in ADL status r/t (related to) neoplasm of bladder (bladder cancer), CHF, Afib, arthritis in hip and weakness dressing, grooming, bathing extensive A1 (assist of one),resident has own teeth; set up and assist with oral cares in AM and before bed; frequently incontinent of bowel and bladder r/t diuretic use, alteration in mobility and malignant neoplasm to bladder, toilet on demand, upon arising, mid am/pm, before/after meals and at hs (bedtime), check/change on NOC (night) rounds.

R17's quarterly MDS dated 4/28/23, indicated intact cognition, required one-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair and walker and diagnoses included: polyosteoarthritis, personal history of transient ischemic attack (stroke like attack), history of falling, and glaucoma (increased pressure within the eyeball, causing gradual loss of sight).

R17's care plan dated 5/3/23, indicated and ADL self-care performance deficit; interventions included dressing, grooming, bathing extensive A1 (assist of one), shower/bath Monday am around 6:30 a.m.

R12's face sheet printed on 5/11/23, indicated diagnose included: cerebrovascular disease (conditions that impact the blood vessels in the brain) with dysarthria (speech disorder cause by paralysis or weakness of the muscles of the

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mouth) and hemiplegia and hemiparesis (paralysis), type 2 diabetes mellitus with neuropathy (nerve damage) and weakness.

R12's significant change MDS assessment dated 3/22/23, indicated moderate cognitive deficit, no behaviors including rejection of care and extensive assist of one for dressing, personal hygiene, toileting and transfers. Walking on and off unit did not occur.

R137's entry MDS dated 5/4/23, indicated admitted on 5/4/23.

On 5/8/23 at 9:48 a.m., R13 was seated in a wheelchair, and indicated staff assistance would take up to an hour or more during the mornings. R13 indicated concerns were brought to facility's attention during her care conference, and further indicated about once or twice a week call lights took one hour to be answered.

On 5/8/23 at 10:02 a.m., R5 was observed in bed and NA-C indicated staff had not provided R5 with morning cares or breakfast due to the shortage of staff.

On 5/8/23 at 10:26 a.m., NA-C assisted R5 in the wheelchair through the hallway to the dining room. NA-C stated R5 was going to breakfast, and ADLs were just completed due to shortage of staff. NA-C further stated R5 was not assisted until now as R5 was a two person assist. NA-C confirmed R5 had not requested to sleep until now, and further verified other residents were still in bed due to shortage of staff.

On 5/8/23 at 10:39 a.m., R137 stated staff were untimely with call light response and had waited up to two hours for staff assistance. R137 stated

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the facility was short staff since her admission on 5/4/23.

On 5/8/23 at 11:29 a.m., R137 indicated staff had not offered or provided morning assist until now and indicated preferred to rise and eat breakfast at 6:00 a.m.

On 5/8/23 at 1:39 p.m., R8 stated, at times, waited for an hour or more for the call lights to be answered. Staff entered the room, turned the call light off, and would not assist with what she needed.

During resident council meeting on 5/9/23 at 1:30 p.m., R11 voiced concerns regarding staffing of the facility and long wait times for call lights to be answered. R20, R33, R7, R13, R2, and R17 all voiced agreement. R11 stated she had filed grievances in the past but quit because "nothing will ever change" and "no one ever listens". R11 added they don't have enough staff and run with 2 staff frequently which has gotten worse over the past 3 months.

On 5/8/23 at 2:31 p.m., during an interview nurse aide (NA)-A stated the facility was short one nursing assistant (NA) today on the day shift, until she arrived at 12:00 p.m. NA-A added yesterday 5/7/23, the facility only had 2 NA's also. NA-A indicated all the residents except R15 were up and dressed for the day when she arrived. NA-A indicated there are 4 residents who require assistance and supervision with eating who were not attended to until she arrived in the dining room around 12:30 p.m. NA-A indicated she called for assistance but no one else arrived to help so she did the best she could. (See F550).

Review of Resident Council Meeting minutes

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response forms included below concerns with staffing and call light response times:
9/22: call light wait times feel too long. State when they call for help they feel that it will be a least 30 minutes before their light is answered. Response from director of nursing (DON) included we are monitoring call light times and working on education with staff.
10/22: Residents feel they wait for their call light to be answered for a long time. Response from DON included reminded to check in on resident when toileted to check when they are done.
11/17/22: Resident are still stating that the call light waits are too long and they are sitting on the toilet way too long waiting for staff. Response from DON included educated staff to be communicating when they have a resident on the toilet to more quickly respond to call light.
2/27/23: When toileting, staff leave and take way too long to come back. Response from DON indicated education given to all nursing staff that when toileting residents, ask if they want to sit a bit or if they should wait because the resident just needs a short time.

On 5/10/23 at 10:19 a.m., NA-D stated at times, she would be responsible for 14-15 residents. NA-D stated the facility was short staffed when two nursing assistants were on the day or evening shift and verified she had worked at the facility during with two NA's. NA-D stated the shortage of staff had caused residents bath missed or delayed, delay in call lights answered, extended wait times, and residents breakfast delayed. NA-D stated 4-5 residents on a normal shift waited until 10:00 a.m. for breakfast. NA-D stated the facility had many residents who required two assist with machines for transfers and caused extended wait times for resident's due to the staff shortage. NA-D indicated

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residents voice concerns about long call light times.

On 5/10/23 at 11:22 a.m., social services (SS)-A confirmed residents brought extended call light and staff shortage concerns to her. She forwarded the concerns to the director of nursing (DON). SS-A indicated call light reports were run and confirmed the facility had extended call light times and would bring the concerns to morning stand up meeting and alerted the director of nursing.

On 5/10/23 at 11:37 a.m., trained medication aide (TMA)-A stated the facility was fully staffed to meet resident needs with three NA's on the day shift. TMA-A stated when two NA's were scheduled, she assisted with resident care and medication pass. TMA-A stated when only 2 NA's were working, residents may miss baths or have extended call light times.

On 5/10/23 at 11:58 a.m., NA-C stated NA's were required for resident morning cares to be completed timely. Further, the facility had many residents who required two assists with transfers and caused extended wait times. NA-C stated the nurse would turn the call light off, however, resident needs were not assisted. NA-C confirmed on 5/8/23, residents were not assisted timely with breakfast or morning cares, and verified residents were in bed until 12:00 p.m. NA-C stated often residents were not assisted with morning cares until 10:00 a.m. NA-C stated was consistiently mandated for the next shift due to staffing shortage. NA-C stated residents in the facility required staff assist to and from dining, resident cares were rushed due to the shortage of nursing staff and residents did not receive the care needed such as bathing, walking, and call

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lights answered timely.

On 5/10/23 at 1:26 p.m., NA-A stated the schedule was short staffed when the facility did not have three NA's on the day shift and with two NA's, the residents had a delay in call lights answered, and baths might get shifted throughout the week or delayed. NA-A stated 10:00 a.m. was the average time for the last resident assisted to the dining room for breakfast.

On 5/10/23 at 02:06 p.m., LPN-C stated three NA's on the day shift was considered fully staffed and 1-2 times per week 2 NA's were scheduled. LPN-C stated when 2 NA's were scheduled, resident baths were missed or pushed to a different day. Nursing staff helped answer call lights and asked the resident to wait for a NA.

During interview on 5/10/23 at 3:08 p.m., the director of nursing (DON) stated they recently hired a staffing person but until then the administrator was completing the staffing schedules. The staffing employee and administrator were not available for interview. The star system was started on February 15th which included a star placed by a staff person's name so if someone called in, that person was mandated to stay for the first part of the next shift and the evening person with a star by their name was mandated to come in early. Staffing was based on casemix and when residents had a higher level of care staffing was adjusted up. The DON stated expectations for answering call lights was within 15 to 20 minutes. The DON added they were working on call light times currently and recently educated staff on call light answering expectations. The DON stated they do not run a shift with 2 NA's on day or evening shift very often. When it happened, baths might not be

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done until later in the afternoon but they were still completed. The DON stated the facility was taking admissions but was very particular and choose only low acuity residents to admit to the facility.

During interview on 5/10/23 at 5:25 p.m., TMA-B stated she started at the facility about 5 or 6 weeks ago and on her 4th day at the facility she was left alone on the floor with no other NA's in the building. TMA-B stated that hasn't happened since but there should be three NA's on day and evening shifts. There had been multiple times with only 2 NA's for the shift.

On 5/11/23 at 9:22 a.m., the DON stated the star system was implemented to assist with staffing schedule, and stated starred staff were expected to stay late or come in early for their scheduled shift. The DON confirmed the implementation of the star system was inconsistent and not always utilized. She verified some days the facility was short staffed due to the star system not implemented or staff not being able to stay past their scheduled shift. The DON indicated residents care with baths, dining delay, extended call light times were a concern with staff shortage. The DON confirmed two NA's was not adequate for the day shift. The DON confirmed with two NA's on the day or evening shift the needs of the residents would not always be met. The DON stated the day shift on 5/8/23, no nurse was nurse scheduled and the DON indicated she worked to cover the nurse shortage. The DON stated she expected call lights answered within 10-15 minutes. The DON indicated she was not aware residents missed baths due to the staff shortage.

On 5/11/23 at 10:37 a.m., NA-B stated her shift

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was supposed to end at 6:30 a.m. however, was mandated and stayed past her scheduled shift as someone did not show. NA-B stated R15's morning cares were not provided yet and would expect R15 was assisted with morning cares and provided breakfast already. NA- B stated the facility had extended call light times, residents missed or had a delay with showers, or the preference of showers was not given due staffing.

The Facility Assessment dated 9/1/2022, indicated average daily census of 28-33 residents. Daily staffing levels were determined by the daily census and resident acuity levels. Staffing was reviewed daily by the scheduler, DON, and administrator to ensure the staffing level supported resident centered care needs. Daily average staffing included registered nurse leadership, 1-2 in AM; Licensed nurses providing direct care; 1-2 in AM, 1-2 PM, and 1 nights. Nurse's aides; 2-3 in AM, 2-3 PM, and 1-2 nights. Trained medication assistant; 0-1 AM, 0-1 PM and 0 on nights.

Review of the facility's staffing schedules for February 15, 2023 through May 2023, revealed an average census of 33-34 residents. The schedules identified 3 NA's on day and evening shifts, but 2 scheduled for night shifts. The schedules lacked required nursing assistants for the following:
February 16th through 28th:
2/16/23 - 1 shift,
2/28/23 - 5 hours on day shift.
March 2023:
3/2/23 - 2 shifts,
3/7/23 - 1 shift,
3/9/23 - 1 shift,
3/10/23 - 1 shift,
3/11/23 - 1 shift plus 5 hours on other shifts,

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3/17/23 - 1 shift,
3/20/23 - 1 shift,
3/21/23 - 1 shift,
3/26/23 - 1 shift,
3/27/23 - 2 shifts,
3/28/23 - 5 hours,
3/29/23 - 1 shift,
3/30/23 - 1 shift.
April 2023:
4/4/23 - 1 shift,
4/9/23 - 1 shift,
4/10/23 - 1 shift,
4/13/23 - 1 shift,
4/14/23 - 1 shift,
4/19/23 - 1 shift,
4/22/23 - 1 shift
4/23/23 - 1 shift
4/24/23 - 3 hours.
May 2023:
5/3/23 - 1 shift,
5/4/23 - 1 shift,
5/5/23 - 1 shift,
5/7/23 - 2 shifts, plus 3 hours.

Facility call light response logs revealed numerous occasions of longer than 15 minutes wait times. The following were examples of the long wait times. These included but were not limited to the following:
3/1/23 - 5/8//23:
R12's longest wait times included: 15 minutes, 29 minutes , 15 minutes, 25 minutes, 32 minutes, 21 minutes, 18 minutes, 24 minutes, 54 minutes, 24 minutes, 18 minutes, 26 minutes, 20 minutes, 30 minutes, 24 minutes, 38 minutes, 27 minutes, 17 minutes, 36 minutes, 42 minutes, 21 minutes, 42 minutes, 34 minutes, 21 minutes, 16 minutes, 19 minutes and 30 minutes.
3/13/23-5/9/23:
R8's longest wait times were 34 minutes, 18

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minutes, 22 minutes, 33 minutes, 21 minutes, 1 hour 26 minutes, 30 minutes, 30 minutes, 18 minutes.
3/9/23-5/9/23
R13's longest wait times were 17 minutes, 19 minutes, 20 minutes, 38 minutes, 21 minutes, 23 minutes, 28 minutes, 22 minutes, 26 minutes, 32 minutes, 31 minutes, 29 minutes, 27 minutes, 43 minutes, 48 minutes, 36 minutes, 37 minutes, 23 minutes, 42 minutes, 34 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 39 minutes, 55 minutes.
4/9/23-5/8/23:
R5's longest wait times were 19 minutes, 28 minutes, 20 minutes, 17 minutes, 15 minutes.
4/16/23-5/9/23:
R17's longest wait times were 17 minutes, 22 minutes, 46 minutes, 40 minutes, 3 hours 40 minutes, 36 minutes, 32 minutes, 22 minutes, 25 minutes, 27 minutes, 22 minutes, 39 minutes, 2 hours and minute.
5/5/23-5/8/23:
R137's longest wait times included: 19 minutes, 43 minutes, 36 minutes, 33 minutes, 52 minutes, 1 hour and 45 minutes, 50 minutes.

Facility's Staffing policy and procedure, undated, included:
- Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.
-Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services.
-Staff numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care.

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2 800	Continued From page 24 -Inquiries or concerns relative to our facility's staffing should be directed to the administrator or his/her designee. Facility's policy and procedure Open Shift Staffing Policy dated 2/22/16, included: -In order to ensure the safety and quality of care for all residents, it is the policy to consistently maintain staffing levels that are at or above the government mandates. Therefore when there are open shifts for any reason on the licensed nursing or nursing assistant schedule, the facility will make every effort to fill the open shifts -Open shifts at the time the schedule is posted or occurring after the schedule is posted in the licensed nursing or nursing assistant department shall be filled by requesting employees to fill such vacancies on a voluntary basis. If a replacement is not found, the following open shift staffing procedure will be utilized -Posted schedules shall designate by an * the individual(s) on each shift who will be expected to cover an open shift after all efforts to fill a vacancy have been exhausted. Employees designated in the shift immediately preceding and following an open shift will be expected to cover 4 hours of the open shift. However, if open shifts occur both prior and after a designated employee's shift, such employee will not be required to cover both shifts. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, medication administration, meals, and eating assistance. The facility should educate	2 800		

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2 800	Continued From page 25 staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. 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 observation, interview, and document review the facility failed to provide sufficient staffing to ensure residents received care and assistance as needed. These deficient practices had the potential to affect all 33 residents who resided in the facility.	2 830	Corrected.	6/30/23

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Findings include:

R5's quarterly Minimum Data Set (MDS) dated 3/14/23, indicated severe cognitive impairment, required two-person physical assist with bed mobility, transfer, dressing, toilet use, and one person physical assist with personal hygiene, utilized a wheelchair and diagnoses included: heart failure, seizure disorder, anxiety disorder, depression, and Alzheimer's disease.

R8's quarterly MDS dated 4/18/20/23, indicated severe cognitive impairment, required one-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair, no rejected care behaviors and diagnoses included: pulmonary fibrosis (lung disease that causes lung tissue to scar, thicken, and stiffen), Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication (spinal nerves get compressed in the lower spine, osteoarthritis of hips, depression, dementia.

R8's care plan dated on 4/7/23, indicated an ADL self-care performance deficit r/t (related to) pulmonary fibrosis, Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication, osteoarthritis of hips, depression, dementia; interventions included dressing, grooming, bathing, eating, extensive A1 (assist of one); shower/bath Wednesday AM hospice, Saturday PM NAR (nursing assistant),

R13's quarterly MDS dated 4/25/20/23, indicated intact cognition, required two-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair and diagnoses included: heart failure and

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osteoarthritis of the right hip.

R13's care plan dated 1/30/23, indicated alteration in ADL status r/t (related to) neoplasm of bladder (bladder cancer), CHF, Afib, arthritis in hip and weakness dressing, grooming, bathing extensive A1 (assist of one),resident has own teeth; set up and assist with oral cares in AM and before bed; frequently incontinent of bowel and bladder r/t diuretic use, alteration in mobility and malignant neoplasm to bladder, toilet on demand, upon arising, mid am/pm, before/after meals and at hs (bedtime), check/change on NOC (night) rounds.

R17's quarterly MDS dated 4/28/23, indicated intact cognition, required one-person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair and walker and diagnoses included: polyosteoarthritis, personal history of transient ischemic attack (stroke like attack), history of falling, and glaucoma (increased pressure within the eyeball, causing gradual loss of sight).

R17's care plan dated 5/3/23, indicated and ADL self-care performance deficit; interventions included dressing, grooming, bathing extensive A1 (assist of one), shower/bath Monday am around 6:30 a.m.

R12's face sheet printed on 5/11/23, indicated diagnose included: cerebrovascular disease (conditions that impact the blood vessels in the brain) with dysarthria (speech disorder cause by paralysis or weakness of the muscles of the mouth) and hemiplegia and hemiparesis (paralysis), type 2 diabetes mellitus with neuropathy (nerve damage) and weakness.

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R12's significant change MDS assessment dated 3/22/23, indicated moderate cognitive deficit, no behaviors including rejection of care and extensive assist of one for dressing, personal hygiene, toileting and transfers. Walking on and off unit did not occur.

R137's entry MDS dated 5/4/23, indicated admitted on 5/4/23.

On 5/8/23 at 9:48 a.m., R13 was seated in a wheelchair, and indicated staff assistance would take up to an hour or more during the mornings. R13 indicated concerns were brought to facility's attention during her care conference, and further indicated about once or twice a week call lights took one hour to be answered.

On 5/8/23 at 10:02 a.m., R5 was observed in bed and NA-C indicated staff had not provided R5 with morning cares or breakfast due to the shortage of staff.

On 5/8/23 at 10:26 a.m., NA-C assisted R5 in the wheelchair through the hallway to the dining room. NA-C stated R5 was going to breakfast, and ADLs were just completed due to shortage of staff. NA-C further stated R5 was not assisted until now as R5 was a two person assist. NA-C confirmed R5 had not requested to sleep until now, and further verified other residents were still in bed due to shortage of staff.

On 5/8/23 at 10:39 a.m., R137 stated staff were untimely with call light response and had waited up to two hours for staff assistance. R137 stated the facility was short staff since her admission on 5/4/23.

On 5/8/23 at 11:29 a.m., R137 indicated staff had

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not offered or provided morning assist until now and indicated preferred to rise and eat breakfast at 6:00 a.m.

On 5/8/23 at 1:39 p.m., R8 stated, at times, waited for an hour or more for the call lights to be answered. Staff entered the room, turned the call light off, and would not assist with what she needed.

During resident council meeting on 5/9/23 at 1:30 p.m., R11 voiced concerns regarding staffing of the facility and long wait times for call lights to be answered. R20, R33, R7, R13, R2, and R17 all voiced agreement. R11 stated she had filed grievances in the past but quit because "nothing will ever change" and "no one ever listens". R11 added they don't have enough staff and run with 2 staff frequently which has gotten worse over the past 3 months.

On 5/8/23 at 2:31 p.m., during an interview nurse aide (NA)-A stated the facility was short one nursing assistant (NA) today on the day shift, until she arrived at 12:00 p.m. NA-A added yesterday 5/7/23, the facility only had 2 NA's also. NA-A indicated all the residents except R15 were up and dressed for the day when she arrived. NA-A indicated there are 4 residents who require assistance and supervision with eating who were not attended to until she arrived in the dining room around 12:30 p.m. NA-A indicated she called for assistance but no one else arrived to help so she did the best she could. (See F550).

Review of Resident Council Meeting minutes response forms included below concerns with staffing and call light response times:
9/22: call light wait times feel too long. State when they call for help they feel that it will be a least 30

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minutes before their light is answered. Response from director of nursing (DON) included we are monitoring call light times and working on education with staff.
10/22: Residents feel they wait for their call light to be answered for a long time. Response from DON included reminded to check in on resident when toileted to check when they are done.
11/17/22: Resident are still stating that the call light waits are too long and they are sitting on the toilet way too long waiting for staff. Response from DON included educated staff to be communicating when they have a resident on the toilet to more quickly respond to call light.
2/27/23: When toileting, staff leave and take way too long to come back. Response from DON indicated education given to all nursing staff that when toileting residents, ask if they want to sit a bit or if they should wait because the resident just needs a short time.

On 5/10/23 at 10:19 a.m., NA-D stated at times, she would be responsible for 14-15 residents. NA-D stated the facility was short staffed when two nursing assistants were on the day or evening shift and verified she had worked at the facility during with two NA's. NA-D stated the shortage of staff had caused residents bath missed or delayed, delay in call lights answered, extended wait times, and residents breakfast delayed. NA-D stated 4-5 residents on a normal shift waited until 10:00 a.m. for breakfast. NA-D stated the facility had many residents who required two assist with machines for transfers and caused extended wait times for resident's due to the staff shortage. NA-D indicated residents voice concerns about long call light times.

On 5/10/23 at 11:22 a.m., social services (SS)-A

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confirmed residents brought extended call light and staff shortage concerns to her. She forwarded the concerns to the director of nursing (DON). SS-A indicated call light reports were run and confirmed the facility had extended call light times and would bring the concerns to morning stand up meeting and alerted the director of nursing.

On 5/10/23 at 11:37 a.m., trained medication aide (TMA)-A stated the facility was fully staffed to meet resident needs with three NA's on the day shift. TMA-A stated when two NA's were scheduled, she assisted with resident care and medication pass. TMA-A stated when only 2 NA's were working, residents may miss baths or have extended call light times.

On 5/10/23 at 11:58 a.m., NA-C stated NA's were required for resident morning cares to be completed timely. Further, the facility had many residents who required two assists with transfers and caused extended wait times. NA-C stated the nurse would turn the call light off, however, resident needs were not assisted. NA-C confirmed on 5/8/23, residents were not assisted timely with breakfast or morning cares, and verified residents were in bed until 12:00 p.m. NA-C stated often residents were not assisted with morning cares until 10:00 a.m. NA-C stated was consistiently mandated for the next shift due to staffing shortage. NA-C stated residents in the facility required staff assist to and from dining, resident cares were rushed due to the shortage of nursing staff and residents did not receive the care needed such as bathing, walking, and call lights answered timely.

On 5/10/23 at 1:26 p.m., NA-A stated the schedule was short staffed when the facility did

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not have three NA's on the day shift and with two NA's, the residents had a delay in call lights answered, and baths might get shifted throughout the week or delayed. NA-A stated 10:00 a.m. was the average time for the last resident assisted to the dining room for breakfast.

On 5/10/23 at 02:06 p.m., LPN-C stated three NA's on the day shift was considered fully staffed and 1-2 times per week 2 NA's were scheduled. LPN-C stated when 2 NA's were scheduled, resident baths were missed or pushed to a different day. Nursing staff helped answer call lights and asked the resident to wait for a NA.

During interview on 5/10/23 at 3:08 p.m., the director of nursing (DON) stated they recently hired a staffing person but until then the administrator was completing the staffing schedules. The staffing employee and administrator were not available for interview. The star system was started on February 15th which included a star placed by a staff person's name so if someone called in, that person was mandated to stay for the first part of the next shift and the evening person with a star by their name was mandated to come in early. Staffing was based on casemix and when residents had a higher level of care staffing was adjusted up. The DON stated expectations for answering call lights was within 15 to 20 minutes. The DON added they were working on call light times currently and recently educated staff on call light answering expectations. The DON stated they do not run a shift with 2 NA's on day or evening shift very often. When it happened, baths might not be done until later in the afternoon but they were still completed. The DON stated the facility was taking admissions but was very particular and choose only low acuity residents to admit to the

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facility.

During interview on 5/10/23 at 5:25 p.m., TMA-B stated she started at the facility about 5 or 6 weeks ago and on her 4th day at the facility she was left alone on the floor with no other NA's in the building. TMA-B stated that hasn't happened since but there should be three NA's on day and evening shifts. There had been multiple times with only 2 NA's for the shift.

On 5/11/23 at 9:22 a.m., the DON stated the star system was implemented to assist with staffing schedule, and stated starred staff were expected to stay late or come in early for their scheduled shift. The DON confirmed the implementation of the star system was inconsistent and not always utilized. She verified some days the facility was short staffed due to the star system not implemented or staff not being able to stay past their scheduled shift. The DON indicated residents care with baths, dining delay, extended call light times were a concern with staff shortage. The DON confirmed two NA's was not adequate for the day shift. The DON confirmed with two NA's on the day or evening shift the needs of the residents would not always be met. The DON stated the day shift on 5/8/23, no nurse was nurse scheduled and the DON indicated she worked to cover the nurse shortage. The DON stated she expected call lights answered within 10-15 minutes. The DON indicated she was not aware residents missed baths due to the staff shortage.

On 5/11/23 at 10:37 a.m., NA-B stated her shift was supposed to end at 6:30 a.m. however, was mandated and stayed past her scheduled shift as someone did not show. NA-B stated R15's morning cares were not provided yet and would

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expect R15 was assisted with morning cares and provided breakfast already. NA- B stated the facility had extended call light times, residents missed or had a delay with showers, or the preference of showers was not given due staffing.

The Facility Assessment dated 9/1/2022, indicated average daily census of 28-33 residents. Daily staffing levels were determined by the daily census and resident acuity levels. Staffing was reviewed daily by the scheduler, DON, and administrator to ensure the staffing level supported resident centered care needs. Daily average staffing included registered nurse leadership, 1-2 in AM; Licensed nurses providing direct care; 1-2 in AM, 1-2 PM, and 1 nights. Nurse's aides; 2-3 in AM, 2-3 PM, and 1-2 nights. Trained medication assistant; 0-1 AM, 0-1 PM and 0 on nights.

Review of the facility's staffing schedules for February 15, 2023 through May 2023, revealed an average census of 33-34 residents. The schedules identified 3 NA's on day and evening shifts, but 2 scheduled for night shifts. The schedules lacked required nursing assistants for the following:
February 16th through 28th:
2/16/23 - 1 shift,
2/28/23 - 5 hours on day shift.
March 2023:
3/2/23 - 2 shifts,
3/7/23 - 1 shift,
3/9/23 - 1 shift,
3/10/23 - 1 shift,
3/11/23 - 1 shift plus 5 hours on other shifts,
3/17/23 - 1 shift,
3/20/23 - 1 shift,
3/21/23 - 1 shift,
3/26/23 - 1 shift,

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3/27/23 - 2 shifts,
3/28/23 - 5 hours,
3/29/23 - 1 shift,
3/30/23 - 1 shift.
April 2023:
4/4/23 - 1 shift,
4/9/23 - 1 shift,
4/10/23 - 1 shift,
4/13/23 - 1 shift,
4/14/23 - 1 shift,
4/19/23 - 1 shift,
4/22/23 - 1 shift
4/23/23 - 1 shift
4/24/23 - 3 hours.
May 2023:
5/3/23 - 1 shift,
5/4/23 - 1 shift,
5/5/23 - 1 shift,
5/7/23 - 2 shifts, plus 3 hours.

Facility call light response logs revealed numerous occasions of longer than 15 minutes wait times. The following were examples of the long wait times. These included but were not limited to the following:
3/1/23 - 5/8//23:
R12's longest wait times included: 15 minutes, 29 minutes , 15 minutes, 25 minutes, 32 minutes, 21 minutes, 18 minutes, 24 minutes, 54 minutes, 24 minutes, 18 minutes, 26 minutes, 20 minutes, 30 minutes, 24 minutes, 38 minutes, 27 minutes, 17 minutes, 36 minutes, 42 minutes, 21 minutes, 42 minutes, 34 minutes, 21 minutes, 16 minutes, 19 minutes and 30 minutes.
3/13/23-5/9/23:
R8's longest wait times were 34 minutes, 18 minutes, 22 minutes, 33 minutes, 21 minutes, 1 hour 26 minutes, 30 minutes, 30 minutes, 18 minutes.
3/9/23-5/9/23

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R13's longest wait times were 17 minutes, 19 minutes, 20 minutes, 38 minutes, 21 minutes, 23 minutes, 28 minutes, 22 minutes, 26 minutes, 32 minutes, 31 minutes, 29 minutes, 27 minutes, 43 minutes, 48 minutes, 36 minutes, 37 minutes, 23 minutes, 42 minutes, 34 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 39 minutes, 55 minutes.
4/9/23-5/8/23:
R5's longest wait times were 19 minutes, 28 minutes, 20 minutes, 17 minutes, 15 minutes.
4/16/23-5/9/23:
R17's longest wait times were 17 minutes, 22 minutes, 46 minutes, 40 minutes, 3 hours 40 minutes, 36 minutes, 32 minutes, 22 minutes, 25 minutes, 27 minutes, 22 minutes, 39 minutes, 2 hours and minute.
5/5/23-5/8/23:
R137's longest wait times included: 19 minutes, 43 minutes, 36 minutes, 33 minutes, 52 minutes, 1 hour and 45 minutes, 50 minutes.

Facility's Staffing policy and procedure, undated, included:
- Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.
-Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services.
-Staff numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care.
-Inquiries or concerns relative to our facility's staffing should be directed to the administrator or his/her designee.

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Facility's policy and procedure Open Shift Staffing Policy dated 2/22/16, included:
-In order to ensure the safety and quality of care for all residents, it is the policy to consistently maintain staffing levels that are at or above the government mandates. Therefore when there are open shifts for any reason on the licensed nursing or nursing assistant schedule, the facility will make every effort to fill the open shifts
-Open shifts at the time the schedule is posted or occurring after the schedule is posted in the licensed nursing or nursing assistant department shall be filled by requesting employees to fill such vacancies on a voluntary basis. If a replacement is not found, the following open shift staffing procedure will be utilized
-Posted schedules shall designate by an * the individual(s) on each shift who will be expected to cover an open shift after all efforts to fill a vacancy have been exhausted. Employees designated in the shift immediately preceding and following an open shift will be expected to cover 4 hours of the open shift. However, if open shifts occur both prior and after a designated employee's shift, such employee will not be required to cover both shifts.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to resident fall incidents. The director of nursing or designee could develop a system to educate staff and develop a monitoring system related to fall incidents. The DON or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring.

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2 830	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure staff provided walking program to meet the assessed needs for 1 of 1 residents (R12) reviewed for restorative services. Findings include: R12's face sheet printed on 5/11/23, indicated diagnoses of cerebrovascular disease (conditions that impact the blood vessels in the brain) with dsyarthria (speech disorder cause by paralysis or weakness of the muscles of the mouth) and hemiplegia and hemiparesis (paralysis), type 2 diabetes mellitus with neuropathy (nerve damage) and weakness. R12's significant change Minimum Data Set (MDS) assessment dated 3/22/23, indicated	2 885	Corrected	6/30/23

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2 885	Continued From page 39	2 885		

moderate cognitive deficit, no behaviors including rejection of care and extensive assist of one for dressing, personal hygiene, toileting and transfers. Walking on and off unit did not occur.

R12's care plan dated 4/3/23, indicated an activities of daily living (ADL) performance deficit and required minimal assist of 1 with gait belt and walker for transfers, moderate assist of 1 for ambulation. R12 was to ambulate 2 times daily with gait belt and front wheel walker with wheelchair to follow behind (2 people). Support the right hand on the 4 wheeled walker.

During interview on 5/8/23 at 9:42 a.m., R12 stated when she first got to the facility she could walk with one foot, but now she was to weak. R12 stated she would like to walk in the hallway but staff don't take her for a walk. R12 added she was currently in therapy related to weakness from a recent Covid-19 infection.

Interview on 5/8/23 at 2:31 p.m., family member (FM)-C stated staff were not walking R12 as her legs were to weak and staff had indicated it wasn't safe.

During observation on 5/10/23 at 1:13 p.m., R12 was in her wheelchair and used one leg to wheel herself to the dining room.

Observation on 5/10/23 at 4:06 p.m., R12 was in her wheelchair in her room. R12 stated therapy did not work with her today and no staff had walked her.

During observation on 5/10/23 at 6:20 p.m., R12 was in the dining room and wheeled self back to her room and into the bathroom. R12 came out of the bathroom a few minutes later and was sitting

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2 885	Continued From page 40	2 885		

in her room in her wheelchair. At 7:17 p.m., staff entered room, assisted R12 into her pajamas, and then watched television from her wheelchair.

Interview on 5/10/23 at 1:53 p.m., FM-D stated R12 was currently in therapy because staff "never ask her to walk at all". FM-D added she was at the facility all day and had "never once seen staff walk R12" even though therapy had recommended it in the past. FM-D stated R12 also told her staff do not walk her.

A progress note dated 3/2/23 at 5:14 p.m., licensed practical nurse (LPN)-A indicated recommendations from therapy were received and directed: Bed mobility, minimal assist of one. Transfers, minimal assist of 1 with gait belt and walker. Ambulation, assist of one with use of gait belt and front wheeled walker (FWW) with wheelchair to follow, to tolerance. Remind to stand tall and support right hand on FWW.

A Therapy Transfer Recommendations form dated 3/2/23, indicated ambulation to occur two times per day with assist of 1, wheelchair to follow with second person, gait belt and front wheeled walker to tolerance and remind to stand tall, support right hand on FWW.

A Physical Therapy Discharge Note dated 3/14/23, physical therapist (PT)-B indicated R12 was at baseline on 2/6/23. R12 ambulated upwards of 50 feet with FWW and contact guard assist with cues and difficulty with turns. At discharge on 3/14/23, R12 was inconsistent with distances which was dependent on blood glucose levels and fatigue. Discharge recommendations included a walking program with caregivers, FWW and wheelchair to follow, with assist of 1 for transfers.

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2 885	Continued From page 41	2 885		

Review of point of care ambulation record from 3/3/23 through 4/16/23, included:
Walk in hallway: Not applicable (NA) 86 times out of possible 90 attempts. Walking occurred 4 times requiring limited to extensive assistance.
Walk in room: NA 87 times out of possible 90 attempts. Walking occurred 3 times requiring limited to extensive assistance.

Interview and observation on 5/11/23 at 8:57 a.m., R12 was in the dining room eating breakfast in her wheelchair. R12 used one leg to wheel self back to her room. R12 stated she wanted to walk more and felt she was in the wheelchair too much. R12 added when she came to the facility she used the walker and now she doesn't at all and was "stuck" in this wheelchair.

During interview on 5/11/23 at 9:04 a.m., NA-C stated they have walked R12 in the past but currently she was working with therapy and were told not to.

Interview on 5/11/23 at 9:06 a.m., physical therapy aide (PTA)-E stated therapy started working with R12 after she had Covid-19 on 4/16/23. PTA-E indicated she was an assist of 2 at that time and was currently in between 1 and 2 assist. PTA-E stated R12 was supposed to be on a walking program prior to this and if staff were not walking her, they should have been.

Interview on 5/11/23 at 10:38 a.m., nursing assistant (NA)-B stated she did not think they were walking R12 at all since she was admitted, she was not on an ambulation program.

Interview on 5/11/23 at 1:07 p.m., the director of nursing (DON) stated PT left recommendations

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2 885	Continued From page 42 on the desk and when she saw R12's order sitting there shortly after she started at the facility at the end of March, asked staff what happened next, staff were unsure. The DON stated a new process was put into place that included review by the interdisciplinary team (IDT). IDT evaluated for realistic expectations and then care planned and added to tasks. The DON included her expectation was staff would complete the task and when resident refused, it was reported to either the nurse or her, and documented. A policy and procedure on ambulation was requested and none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 885		

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		6/30/23

Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:

A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and

B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to comprehensively assess the skin for pressure ulcer (PU) for 1 of 1 resident (R21) who was diagnosed with pressure ulcer following a re-admission from the hospital.

Corrected.

Findings include:

R21's face sheet printed 5/11/23, included diagnosis of fracture of neck of left femur, pulmonary fibrosis (lung tissue scars, thickens and stiffens), fracture of left pubis (pelvic bone), multiple fractures of ribs right side, heart failure, dementia, neoplasm (abnormal growth of tissue) of left kidney, and repeated falls.

R21's significant change Minimum Data Set

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(MDS) dated 2/8/23, indicated severe cognitive impairment, and delirium which included inattententiveness that comes and goes. Activities of daily living (ADL's) included extensive assist of 2 persons for transfers, bed mobility, personal hygiene and toileting. R21 was at risk for pressure ulcers but had no skin issues currently.

R21's current care plan dated 2/2/23, last revised 3/23, indicated impairment to skin integrity related to immobility with coccyx wound related to advanced age, terminal illness and fragile skin. Interventions included: turn and reposition every 2-3 hours, encourage good nutrition and hydration in order to promote healthier skin, identify/document potential causative factors and eliminate/resolve where possible. Follow facility protocols for treatment of injury.

An Incident Review and Analysis form dated 1/29/23 at approximately 2:30 a.m., indicated R21 was found on the floor in her bathroom on her left side and back. R21 was transferred to the emergency department (ED) via ambulance and admitted with diagnosis of left femur fracture. R21 returned to the facility on 2/2/23, with hospice services.

A hospital discharge summary dated 2/2/23, indicated principal diagnosis of fracture of neck of femur with active problems listed as renal mass, heart failure and frequent falls. R21 had surgical intervention on 1/30/23. Recovery was complicated by increased confusion and rapid heart rate. After discussion with the family, hospice services and comfort care was implemented upon discharge.

R21's Readmit Data Collection form dated 2/2/23 and completed by licensed practical nurse

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(LPN)-A at 10:39 a.m., indicated a change in activity level and activities of daily living (ADL) dependencies with Foley catheter in place. Skin assessment included left trochanter (hip) surgical incision intact with 15 staples, face with several areas of bruising related to fall and bilateral arms with several bruises noted. The Readmit Data Collection form lacked evidence of deep tissue injury. Further, the record lacked evidence a comprehsive skin assessment was completed at time of re-admission.

A progress note dated 2/7/23, by medical provider (MP)-L, indicated R21 had left hip fracture with surgical repair on 1/30/23. R21 experienced significant delirium post-op and was enrolled in hospice upon return back to the facility on 2/2/23. R21 had been lethargic and sleeping most of the time. R21 had no rashes, wounds or lesions to exposed skin. Has extensive facial bruising, left hip incision with no redness or drainage. Anticipate progressive decline with comfort focused care.

R21's weekly skin inspection on 2/8/23, by registered nurse (RN)-A removed a mepliex from the coccyx area and noted a blister on left buttock, 2.0 x 2.6 cm, with abrasion on left lower buttock 1.5 x 1.5 cm. Unstageable purple area 5.1 x 2.6 cm on coccyx (most distal portion of the spine). Left lateral buttock has a 2.6 x 1.0 cm intact blister. Right buttock had an area of discoloration 1.0 x 1.2 cm.

A wound care consult dated 2/14/23, medical provider (MP)-M indicated deep tissue pressure injury to coccyx. Wound likely to continue to evolve. Pressure relief/off loading per facility protocol.

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A weekly wound evaluation form dated 2/15/23, LPN-A indicated coccyx with a deep tissue injury 9 cm by 7 cm. Description of wound included area will likely continue to evolve. Scant amount of serosanguious (pale red made of serum and red blood cells typically seen as wound is trying to heal) drainage noted.

Wound evaluation form dated 2/17/23, LPN-A indicated coccyx with pressure wound, unstageable 6 x 4 x 0.2 depth with 100% slough (layer of dead tissue) present. Description included wound bed was grayish slough with noted yellowish slough around edges. Moist in appearance. Provider was updated with new orders for wound care. MP-M to place calcium alginate silver to wound bed and cover with silicone foam border dressing three times a week and as needed.

A wound care consultant progress note dated 2/21/23, MP-M indicated coccyx pressure ulcer deteriorating 11 x 8 x 0 with light serosanguinous drainage.

Wound evaluation form dated 2/22/23, LPN-A indicated unstageable coccyx wound 11 x 8 x 0 with wound bed 100% necrotic with light serosanguinous drainage.

A wound evaluation dated 3/6/23, by MP-M indicated stage 4 coccyx pressure ulcer, improving. Wound is 9 x 7 x 0.8 27 with undermining present. Heavy serosanguinour drainage. 35% necrotic tissue and 65% granulation. No bone visible. Wound is almost free of slough, necrotic tissue. Does expose muscle/fascia level.

Wound evaluations and measurements continued

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weekly by counsulting wound MP-M and LPN-A with wound improving.

Most recent consulting wound care progress note dated 5/4/23, MP-M indicated hospice services remain in place. Follow up management of deep tissue injury evolved to stage 4 pressure ulcer. Wound was improving with measurements of 3 x 0.7 x 1.2. Moderate serosanguinous drainage continued with 100% granulation with muscle exposed but no bone. Wound continued to improve week over week.

Most recent wound evaluation 5/5/23, LPN-A indicated a stage 4 pressure ulcer on coccyx 3 x 0.7 x 0.3 with 100% granulation. Wound was healing, no bone exposure with minimal drainage and no pain noted. Current intervention include cleanse with Vashe wound cleanser. Moisten gauze and allow to remain on wound bed for 3-5 minutes with each dressing change. Apply skin prep to wound edges. Pack wound with silver calcium alginate. Cover with silicone foam border dressing. Change three times per week and as needed.

A Braden Scale (measures elements of risk for development of pressure ulcers) was completed 5/8/23. R21 was identified as high risk.

Observation 5/9/23, R21 was in her chair in the dining room for music. Cushion was present in wheelchair.

Observation and interview on 5/9/23 at 1:59 p.m., R21 did not respond to questions. R21 was lying in bed on her left side with air mattress present on the bed.

Observation on 5/10/23 at 3:00 p.m., R21 was

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taken back to her room after attending activity and was transferred to her bed and was lying on her left side.

Observation on 5/10/23, at 4:43 p.m. R21 was hollering out for help and began to climb out of bed. The director of nursing (DON) and nursing assistant (NA) responded immediately and R21 was transferred back to her chair and out to the common room. R21 remained in wheelchair in common room until 6:15 p.m. when an aide assisted R21 back to her room, checked and changed and settled into bed on her right side.

Interview on 5/10/23, at 3:30 p.m., LPN-A stated she assessed the wounds she could visualize upon return and assumed the nursing staff would do a complete skin check upon admission. LPN-A confirmed she did not observe the coccyx area upon return so was unsure if deep tissue injury was present on admission or not.

Interview on 5/11/23, at 10:20 a.m., NA-C indicated she doesn't remember if R21 was admitted with a sore on her coccyx or if a dressing was present. NA-C added they were repositioning her every 1-2 hours when she initially returned. Now they are doing at least every 2 hours.

Interview on 5/11/23, at 10:40 a.m., NA-B indicated she wasn't sure if R21 had a sore on her coccyx or dressing present when she returned from the hospital. NA-B added she normally worked night shift and they were repositioning R21 every 1-2 hours.

During interview on 5/11/23 at 11:10 a.m., the DON indicated she expected a full head to toe skin inspection upon readmission to the facility.

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She confirmed one was not completed for R12 upon re-admission.

Interview on 5/11/23, at 3:53 p.m., with hospice registered nurse (RN)-B indicated she was not the admission nurse for R21. RN-B reviewed R21's record and indicated on 2/2/23 admission documentation there was no coccyx wound documentation present but facial areas with bruise, surgical incision on hip was present. Documentation included important to reposition every two hours and an air mattress was ordered on admission.

Interview on 5/12/23 at 8:29 a.m., MP-L indicated she was not sure if the resident was admitted with the wound present or if it occurred after admission. MP-L added given R21's health and the health condition she returned in, it was difficult to say if the wound began in the hospital or at the facility or if it was preventable. MP-L added staff were repositioning R21 every 1-2 hours and the family was always present advocating for repositioning.

A Skin Assessment and Wound Management policy and procedure dated 5/27/22 included:
-A pressure ulcer risk assessment will be completed for every resident upon admission (Braden Scale).
-Staff will perform routine skin inspections with daily care.
-Nurses are to be notified if skin changes are identified.
-A weekly skin inspection will be completed by licensed staff.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents at risk for pressure ulcers to assure

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2 900	Continued From page 50 they are accurately assessed and receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dependent residents receive assistance with personal hygiene and activities of daily living (ADL's) for 2 of 9 residents (R8, R15) who were dependent on staff for personal hygiene. Findings include: R8's quarterly Minimum Data Set (MDS) dated 4/18/2023, indicated: severe cognitive impairment; required one-person physical assist	2 920	Corrected.	6/30/23

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2 920		2 920		

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with bed mobility, transfer, dressing, toilet use, and personal hygiene; utilized a wheelchair; no rejected care behaviors. Diagnoses included: pulmonary fibrosis (lung disease that causes lung tissue to scar, thicken, and stiffen), Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication (spinal nerves get compressed in the lower spine), osteoarthritis of hips, depression, and dementia.

R8's care plan dated 4/7/23, indicated: ADL self-care performance deficit r/t (related to) pulmonary fibrosis, Alzheimer's disease, anxiety, spinal stenosis of lumbar region with neurogenic claudication, osteoarthritis of hips, depression, dementia; interventions included: extensive A1 (assist of one) with dressing, grooming, bathing, eating,); shower/bath Wednesday am with hospice, Saturday pm with NAR (nursing assistant).

R8's progress notes lacked evidence of any refusal of care.

On 5/08/23 at 1:41 p.m., R8 was observed with white and black chin hairs of varied lengths (approximately ½ inch). R8 stated she would like her chin hairs shaved "to look like a lady." R8 stated shaving was not offered or completed by staff.

On 5/09/23 at 10:12 a.m., R8 was observed seated in a wheelchair, in the day room with long chin hairs visible. Nursing assistant (NA)-A stated R8's morning cares were completed by night shift.

On 5/10/23 at 10:14 a.m., the director of nursing (DON) stated shaving of residents was expected with morning cares and when facial hair was

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observed. R8 told the DON she wanted the facial hair shaved. The DON confirmed R8's chin hairs were long and needed shaving and confirmed staff had not completed the task for R8.

On 5/10/23 at 10:16 a.m., trained medication aide (TMA)-A stated staff who provided morning cares were expected to shave the residents when facial hair was visible. TMA-A stated overnight shift provided R8 with morning cares.

On 5/10/23 at 12:12 p.m., NA-C stated night shift provided R8's morning cares and was dependent on staff assistance with facial hair removed. NA-C stated residents were expected shaved when long chin hairs were visible.

R15's quarterly Minimum Data Set (MDS) dated 4/18/20/23, indicated severe cognitive impairment; required one-person physical assist with bed mobility,dressing, eating, toilet use, personal hygiene, two person physical assist with transfer, and utilized a walker. Diagnoses included: heart failure, Alzheimer's disease, depression, muscle weakness, and history of falling.

R15's care plan dated 5/10/23, indicated an ADL self-care performance deficit r/t Alzheimer's, dementia, heart failure, COPD, weakness; resident will be neat, clean and odor free with assistance from staff. Interventions included extensive A1 with dressing and grooming; extensive A2 with bathing; eating independent after set up, ensure out for meals to dining room, and eats slow.

On 5/08/23 at 9:35 a.m., R15 was lying in bed and further indicated had not eaten breakfast.

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On 5/08/23 at 12:32 p.m., observed NA-C enter R15's room, changed R15's brief and walked with R15 through the hallways and proceeded to the dining room for lunch. NA-C stated she was unaware if R15 was provided morning ADL cares or ate breakfast. NA-C was unsure whose responsibility R15's morning cares were today.

On 5/08/23 at 3:48 p.m., the DON confirmed staff had not provided R15 morning cares or breakfast today and stated the disruption of the schedule caused staff to fall behind with morning cares. DON stated R15 was provided an afternoon shower.

On 5/10/23 at 1:31 p.m., NA-A confirmed on 5/8/23, she arrived at work around 12:00 p.m. and R15's morning cares nor breakfast had been provided prior to her shift.

On 5/11/23 at 9:22 a.m., the DON stated staff were expected to assist residents with morning cares. Residents were not expected to still be in bed at 10:00 a.m.

On 5/11/23 at 9:48 a.m., R15 was observed in her bed under the covers.

On 5/11/23 at 10:35 a.m., licensed practical nurse (LPN)-A stated her shift "just" started and confirmed R15 was not assisted with breakfast or morning cares today.

On 5/11/23 at 10:37 a.m., NA-B verified she had not had time to complete R15's morning cares today. NA-B stated R15 was dependent on staff for ADL cares and was expected to have had breakfast already.

On 5/11/23 at 11:41 a.m., R15 was seated in the

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dining room and ate breakfast.

Facility policy titled Activities of Daily Living (ADLs)/ Maintain Abilities Policy dated 3/31/23, indicated:

Intent: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

3. The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems.

4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on activities of daily living (ADLs) for dependent

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2 920	Continued From page 55 residents to ensure accuracy; then educate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) days	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishwashing sanitization was appropriately monitored and failed to ensure storage of food brought in for, or by residents, was safe for consumption. This had the potential to effect all residents in the facility. Findings include: UNLABELED AND UNDATED FOOD On 5/8/23 at 9:15 a.m., a refrigerator in a kitchenette located in the dining room accessible to residents, family and visitors who brought food in from outside the facility was inspected. Food and beverages observed in this refrigerator included the following: 1. Thick it advantage for coffee, opened, undated and labeled expired 1/21/24. 2. Lyon prune juice opened and undated, 3/4 empty with expiration date of 8/23. 3. 1 storage bowl that contained corn on the cob	21015	Corrected.	6/30/23

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that appeared shriveled, undated and unlabeled.
4. 1 storage bowl that contained a shrimp salad, undated and unlabeled.
5. A chocolate pudding dessert on a cookie sheet 3/4 empty covered with tin foil unlabeled and undated.
6. 2 salad dressing bottles undated and unlabeled 1/2 empty. No expiration present.
Multiple other beverages unopened were present.

During interview on 5/9/23 at 11:01 a.m., cook (C)-A indicated the refrigerator was for residents only. Residents were to date and label the food they put in there. C-A was unsure who monitored the refrigerator.

On 5/9/23 at 7:33 a.m., opened, undated and expired foods listed above remained in the kitchenette refrigerator.

Interview on 5/11/23 at 9:35 a.m., C-B stated the refrigerator in the dining room was cleaned out today and items not labeled or dated were discarded including the 2 storage bowl containers. C-B confirmed beverages for meals were stored in the refrigerator along with residents foods. C-B confirmed all resident foods should be labeled with resident name and dated. All facility products were labeled with date opened. If unlabled or undated, should be discarded.

A facility policy and procedure for Food brought into a Monarch Healthcare Management Facility dated 4/97 included:
-Purpose is to provide each resident with safe, nutritious, healthy food products.
-If a resident's family's should bring in food for their loved one, and this food can be stored in a sanitary manner in the resident's room, staff will

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accept this and monitor the use.

DISHWASHER:
On 5/8/23 at 8:39 a.m., during initial tour of the kitchen and dishwashing area, C-B indicated the dishwasher was a chemical dishwasher which was rented. The rental company supplied the products and checked the machine.

Observation and interview on 5/9/23 at 10:39 a.m., C-C ran dirty dishes through the dishwasher. C-C stated it was a low temperature dishwasher but she did not check the dishwasher with any chemical strips. A clip board hung on the opposite wall that included a Dishmachine Temperature Log (Low temperature). It included a column for wash temperature 120-140 degrees Fahrenheit (F) and Chlorine PPM (parts per million) 50-100. C-C stated they documented the temperature of the wash and rinse cycles and documented results on that form. C-C added she had a hard time seeing the temperature gauge. Next to the clip board was a container labeled Chlorine Strips. C-C stated she did not know what they were for and the last time she tried to use them on dishwasher, the strip remained white. C-C then went into another room and brought out PH (a figure expressing the acidity or alkalinity of a solution) strips and attempted to check dishwasher PH which turned the strip white (no reading). C-C attempted the chlorine strips which turned a blue color indicting 50 PPM of chlorine.

During interview on 5/9/23 at 10:50 a.m., C-A indicated the rinse 50-100 PPM chlorine column on the Dishmachine Temperature Log was the rinse temperature. C-A got PH Paper and attempted testing dishwasher which turned the PH paper white (not an actual reading). When shown the chlorine strips, C-A stated she had not

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been using them.

Interview on 5/9/23 at 12:55 p.m., C-B indicated he was not aware of the chemical strips and the dishwasher needed to be tested. Behind the Dishmachine Temperature Log was a policy and procedure titled Dishwasher which included checking the temperature to insure wash water was 150-160 degrees Fahrenheit (F) and rinse water was 180 degrees F. Record temperature per policy of the facility. C-B indicated it needed to be changed to the chemical dishwasher policy and procedure.

Interview on 5/11/23 at 9:35 a.m., C-B stated the proper policy and procedure for dishwasher low temperature (chemical sanitization) was located. Staff needed to be properly educated on the procedure today.

A policy and procedure titled Sanitization last revised October 2008 included:
- High temperature dishwasher wash temperature 150-165 degrees F for at least 45 seconds with rinse temperature 165-180 degrees for a least 12 seconds.
-Low temperature dishwasher (chemical sanitization) wash temperature 120 degrees F and final rinse with 50 PPM chlorine for a least 10 seconds.

SUGGESTED METHOD OF CORRECTION:
The dietary manager, registered dietician, or administrator, could ensure appropriate infection control technique related to dishwashing is maintained in the kitchen . The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits

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21015	Continued From page 59 periodically to ensure compliance. The facility could report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 4 of 4 residents (R24, R15, R26 and R3) who required supervision and assistance with dining. Findings Include: During observation on 5/8/23, at 12:27 p.m., R26 and R3 sat at one table with beverages in front of them with food just delivered. R24 and R15 sat at the next table with food delivered at 12:25 p.m. R3, R24 and R15 made no attempt to eat. Trained medication assistant (TMA)-A sat with R26 to assist with meal. No encouragement was offered to R24, R15 or R3 to eat. At 12:43 TMA-A indicated to R26 she would be right back and went to the nurses station and began passing medications. At 12:52 p.m. nursing assistant	21805	Corrected	6/30/23

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(NA)-A arrived into dining area and stood next to R3 and assisted R3 with a forkful of vegetables. NA-A went to the next table, assisted R15 with a forkful of hamburger hotdish. Next, NA-A assisted R24 to take a bite but R24 refused. At 12:54 p.m., NA-A went to kitchen area. At 12:55 p.m., NA-A returned, and while standing, gave R3 another bite of food. She went to R24 to try to give a bite of food, which she again refused. At 12:56 p.m., R26 attempted to get a spoonful of hotdish, but was not successful. At 12:57 p.m., NA-A went back to R3 and gave her another bite of vegetables. At 12:58 p.m. NA-A returned to R24 and attempted to give her a forkful of food which she again refused. R15 made no attempt to eat. At 1:00 p.m., NA-A left the dining room and returned at 1:03 p.m. She attempted to assist R26 and R3, both refused. At 1:05 p.m., Na-A went to kitchen area, returned, and assisted R3 with a spoonful of desert. She went to another table, encouraged R24 and R15 to eat. At 1:08 p.m., NA-A left the floor. R24, R15, R26, and R3 made no further attempt to eat. Food was not offered to be reheated. NA-A remained standing throughout meal process. There were no other staff present in the dining room throughout this time.

R24's face sheet printed 5/11/23, identified a diagnoses of Alzheimer's disease, and dysphagia (difficulty in swallowing food or liquid).

R24's quarterly, Minimum Data Set (MDS) assessment, dated 1/31/23, identified severe cognitive impairment, and required supervision of one person to physical assist for eating.

R24's care plan dated 1/20/23, identified an alteration with nutrition related to mechanically altered diet and requires supervision to limited to

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21805	Continued From page 61 extensive assist, requiring cueing, assist to eat. R15's face sheet printed 5/11/23, identified a diagnoses of Alzheimer's disease, dementia with behavioral disturbance and generalized weakness. R15's admission MDS assessment dated 4/18/23, identified severe cognitive impairment, and required supervision of one person physical assist. R15's care plan dated 4/9/23, identified a problem with self-care performance of activities of daily living and is independent with eating after set up. Eats slow, needs encouragement R26's face sheet printed 5/11/23 indicated diagnosis of Alzheimer's disease, diabetes mellitus and dementia with behavioral disturbance. R26's admission MDS assessment dated 5/1/23 indicated severe cognitive impairment and required extensive assistance of one personal physical assist for eating. R26's care plan dated 4/25/23, indicated an alteration in activities of daily living and required extensive assist of 1 with eating. R3's admission record, printed 5/11/23, identified a diagnoses of Alzheimer's disease, and dementia with behavioral disturbance. R3's annual MDS dated 3/1/23, indicated severe cognitive impairment and required supervision of one person physical assist with eating. R3's care plan dated 3/1/23 indicated an activities	21805		

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21805	Continued From page 62 of daily living deficit and requires supervision with setup and cues and assist as needed. During an interview on 5/8/23, at 2:31 p.m., NA-A stated there were only two NA's in the facility until noon when she arrived. She called for assistance in the dining room twice without any response from the other nursing staff members. NA-A stated there were two residents that required feeding at one table and the other two require supervision and encouragement to eat. NA-A stated "we needed more help in the dining room today than we had". During interview on 5/10/23 3:08 p.m., the director of nursing (DON) stated on Monday 5/8/23, staffing was a challenge as she was unaware the facility was short. The DON confirmed NA's were expected to sit while assisting residents with meals and food should be reheated when sitting longer than 5-10 minutes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures related to dignified dining are correct. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures related to dignified dining. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment;	21830		6/30/23

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notification of family members.

(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

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21830	Continued From page 64 (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: ______ B. WING ______	C 05/11/2023

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21830	Continued From page 65 damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure identified preferences for rising were honored and implemented for 1 of 1 resident (R28) reviewed for choices. Findings include: R28's quarterly Minimum Data Set (MDS) dated 3/20/23, indicated R2 had moderate cognitive impairment and demonstrated no physical, verbal or other behavioral symptoms; required two-person physical assist with bed mobility, transfer, toilet use; one person physical assist with dressing, personal hygiene; utilized a walker and wheelchair. Diagnoses included: depression, urinary incontinence, obesity, osteoarthritis of hip (breakdown of joint cartilage and underlying bone), and heart failure. R28's care plan dated 3/27/23, indicated ADL (activity daily living) self-care performance deficit r/t (related to) heart failure, bilateral osteoarthritis of the hips, trochanteric bursitis left hip, obesity, bilateral primary osteoarthritis of knee, and cognitive impairment. Interventions included: neat, clean, and odor free with assistance from staff; maintain current level of function; and extensive A1 (assist of one) with dressing, grooming, bathing, and eating. Get resident up on NOC (night) shift, and prefers to be up in dining	21830	Corrected.	

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21830	Continued From page 66	21830		

Continued From page 66

room around 6:00 a.m.

Progress note dated 5/4/23 at 2:31 p.m., health information management (HIM)-F indicated, "Writer was helping check call lights and checked with resident to see what he needed. He wanted to talk to someone about the fact that he wants to get up early, between 5 and 5:30 and have breakfast early per his care-plan. He was in bed today until at least 10 and did not get to eat until 10:30 and eluded to the fact that it has happened more than once recently. Writer assured him that I would notify the appropriate people to ensure the plan is followed was helping check call lights and checked with resident to see what he needed. He wanted to talk to someone about the fact that he wants to get up early, between 5 and 5:30 and have breakfast early per his care-plan. He was in bed today until at least 10 and did not get to eat until 10:30 and eluded to the fact that it has happened more than once recently. Writer assured him that I would notify the appropriate people to ensure the plan is followed."

Progress note dated 4/27/23, at 6:50 p.m. licensed practical nurse (LPN)-B indicated, R28 stated "I want to get up early in the morning and go out for breakfast but I haven't been able to make it on time."

Grievance summary dated 1/23/23, indicated R28 had requested to get up between 6:00 and 7:00 a.m., was still not up at 9:00 a.m., ate breakfast at 10:15 a.m., and then was not hungry for lunch. Grievance indicated actions taken included R28 was placed on the overnight aide list of residents to get up as it was R28's preference to get up early.

Grievance summary dated 5/4/23, indicated R28

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21830	Continued From page 67	21830		

preferred assistance to the dining room between 5:00 and 5:30 a.m., and it was not happening. Summary of action taken indicated DON added to the care plan to get R28 up on night shift and in the dining room around 6:00 a.m.

On 5/08/23 at 2:40 p.m., R28 stated preferance was to get out of bed shortly after 6:00 a.m. R28 stated 3 out of 7 days of the week he was not provided assistance with morning cares and laid in bed until 10:00 a.m.

On 5/09/23 at 9:49 a.m., family member (FM)-G stated last weekend R28 was not up or assisted out of bed until 10:00 a.m. Staff was questioned, and she was told the facility was "short staffed."

On 5/10/23 at 11:18 a.m., the director nursing (DON) stated residents had the right to choose rising time, expected staff assisted, and honored the preferences.

Facility Policy titled Quality of Life - Resident Self Determination and Participation dated 12/16, indicated:

Policy Interpretation and Implementation

1. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her
interests, values, assessments and plans of care, including:
a. Daily routine, such as sleeping and waking, eating, exercise and bathing schedules.
b. Personal care needs, such as bathing methods, grooming styles and dress.

2. In order to facilitate resident choices, the administration and staff:

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a. Inform the residents and family members of the residents' right to self-determination and participation in preferred activities.
b. Gather information about the residents' personal preferences on initial assessment and periodically
thereafter, and document these preferences in the medical record.
c. Include information gathered about the resident's preferences in the care planning process; and
d. Document and communicate any medical conditions or limitations that may inhibit or interfere with
participation in preferred activities.

SUGGESTED METHOD OF CORRECTION: The director of nursing and social worker could review and revise policies and procedures to ensure residents were offered choices for sleep and bathing. The social worker could inservices all staff to offer residents choices. The director of nursing could monitor staff compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.