

#### 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.

Bayside Manor LLC June 13, 2023 Page 2

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

Bayside Manor LLC June 13, 2023 Page 3

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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

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.

Bayside Manor LLC June 13, 2023 Page 4

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 06/28/2023 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED	
					(	С
		245473	B. WING		05/	11/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSIDE	MANOR LLC			640 THIRD STREET		
				GAYLORD, MN 55334		T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	compliance with Appreparedness Required conducted during a survey. The facility of The facility of The facility is enrolled signature is not required page of the CMS-25 correction is required acknowledge receipt INITIAL COMMENT On 5/8/23 through recertification survey facility. A complaint conducted. Your facility with the requirement	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents. TS  5/11/23, a standard sy was conducted at your investigation was also cility was NOT in compliance ats of 42 CFR 483, Subpart B,	FO	00		
LABORATORY	In addition to the refollowing complaints The following complete deficiency issued. H54732088C (MN0H54732090C (MN0H54732108C (MN0H54739135C (MN0H54739921C (MN0H54739921C (MN0H54732026C (MN0H54732026C (MN0H54732031C (MN0H547320)C (MN0H547320)C (MN0H547320)C (MN0H547320)C (MN0H547320)C (MN0H547320)C (MN0H54720)C (MN0H54	laints were reviewed with no 0087517) 0086351) 0084339) 0088066) 0091604) 0092249) laints were reviewed. 0093129 and MN00093241) sued at F580 0090107) with a deficiency	NATURE	TITLE		(X6) DATE
		EK/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	IIILE		
⊨lectron	ically Signed					06/19/2023

(X2) MULTIPLE CONSTRUCTION

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	l \	E SURVEY IPLETED		
		245473	B. WING		05/	C /11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 550	issued at F677, F68 H54732102C (MN0 issued at F580 H54732106C (MN0 issued at F725 H54732107C (MN0 issued at F725 H54732109C (MN0 issued at F689  The facility's plan of as your allegation of Departments accepted in ePOC, year the bottom of the form. Your electronia be used as verificated Upon receipt of an anonsite revisit of you validate that substated regulations has been Resident Rights/ExcCFR(s): 483.10(a) (1) §483.10(a) Resident The resident has a self-determination, access to persons a outside the facility, it is section. §483.10(a)(1) A fact with respect and dignerical resident in a manner promotes maintenance.	0086778) with a deficiency 36, and F725 0093219) with a deficiency 0090098) with a deficiency 0090102) with a deficiency 0087632) with a deficiency f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required a first page of the CMS-2567 ic submission of the POC will ion of compliance.  acceptable electronic POC, and a facility may be conducted to ntial compliance with the en attained. Hercise of Rights 1)(2)(b)(1)(2)		550		6/30/23
	,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245473	B. WING			C 05/11/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	11/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (  (EACH CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APPOPER (  DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 550	§483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of services residents regardles.  §483.10(b) Exercise The resident has the rights as a resident or resident of the US\$483.10(b)(1) The resident can exercise interference, coercifrom the facility.  §483.10(b)(2) The free of interference reprisal from the farights and to be supexercise of his or his subpart. This REQUIREMED by:  Based on observation review the facility f	cility must protect and of the resident.  Facility must provide equal are regardless of diagnosis, and, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all sof payment source.  The of Rights are right to exercise his or her of the facility and as a citizen nited States.  Facility must ensure that the se his or her rights without on, discrimination, or reprisal are sident has the right to be a coercion, discrimination, and cility in exercising his or her opported by the facility in the er rights as required under this er rights as required under this er and document and to provide a dignified or 4 of 4 residents (R24, R15, equired supervision and	F 5	F550  Submission of this Response a Correction is not a legal admiss deficiency exists or that this Sta Deficiency was correctly cited, not to be construed as an admifault by the facility, the Executivor any employees, agents or ot individuals who draft or may be	sion that a atement of and is also ssion of e Director her		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		\	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	11/2023	
INAIVIL OI I	NOVIDER OR GOLT LIER			640 THIRD STREET	ODL		
BAYSIDE	MANOR LLC						
	T			GAYLORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 550	Continued From pa	age 3	F 5	50			
		delivered. R24 and R15 sat at		in this Response and Plan	of Correction		
		food delivered at 12:25 p.m.		In addition, preparation and			
		nade no attempt to eat.		this Plan of Correction does			
	•	assistant (TMA)-A sat with		an admission or agreement			
		neal. No encouragement was		the facility of the truth of any	,		
	offered to R24, R15	5 or R3 to eat. At 12:43		or the correctness of any co	onclusions set		
	TMA-A indicated to	R26 she would be right back		forth in the allegations.			
		rses station and began passing					
		2:52 p.m. nursing assistant		Accordingly, the Facility has	• •		
		dining area and stood next to		submitted this Plan of Corre	•		
		3 with a forkful of vegetables.		the resolution of any appear	•		
		ext table, assisted R15 with a er hotdish. Next, NA-A assisted		filed solely because of the r under state and federal law	•		
		out R24 refused. At 12:54 p.m.,		submission of a Plan of Cor			
		en area. At 12:55 p.m., NA-A		ten (10) days of the survey			
		standing, gave R3 another		to participate in Title 18 and			
	,	ent to R24 to try to give a bite		programs. This Plan of Co			
		again refused. At 12:56 p.m.,		submitted as the facility's cr			
		et a spoonful of hotdish, but		allegation of compliance.			
	was not successful	l. At 12:57 p.m., NA-A went					
		e her another bite of		-The process for satisfying			
		8 p.m. NA-A returned to R24		requirement has been revie			
		ive her a forkful of food which		revised as needed, to ensur			
		R15 made no attempt to eat.		are provided with a dignified	ddining		
	•	left the dining room and		experience.			
	-	m. She attempted to assist refused. At 1:05 p.m., Na-A		-Residents residing in this fa	acility who		
		a, returned, and assisted R3		require supervision and ass	•		
		desert. She went to another		dining have the potential to			
	·	R24 and R15 to eat. At 1:08			De director.		
	,	floor. R24, R15, R26, and R3		-Education will be provided	to necessarv		
	•	tempt to eat. Food was not		Bayside Manor staff utilizing	•		
		ted. NA-A remained standing		Healthcare Policy and proce			
	throughout meal pr	ocess. There were no other					
	staff present in the	dining room throughout this		-Necessary staff have been			
	time.			this rule and regulation. R24	, , ,		
				R26, along with all other res			
	-	rinted 5/11/23, identified a		require assistance with eati	•		
	I diadnoses of Alzhe	imer's disease, and dysphagia		assisted at all meals in a magnetic and a magnetic	anner that is		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	1 ` ′	(X3) DATE SURVEY COMPLETED	
		245473	B. WING			C 11/2023	
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP 640 THIRD STREET GAYLORD, MN 55334	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	R24's quarterly, Massessment, dater cognitive impairmed one person to phys.  R24's care plan da alteration with nutral altered diet and reextensive assist, r.  R15's face sheet produced diagnoses of Alzhe behavioral disturbances.  R15's admission May 18/23, identified and required superassist.  R15's care plan da with self-care performances in the performance of Alzhe mellitus and demonstrated severe of required extensive physical assist for R26's care plan da severe of required extensive physical assist for R26's care plan da severe of required extensive physical assist for R26's care plan da severe of required extensive physical assist for R26's care plan da severe of required extensive physical assist for R26's care plan da severe plan da seve	inimum Data Set (MDS) d 1/31/23, identified severe ent, and required supervision of sical assist for eating.  ated 1/20/23, identified an rition related to mechanically quires supervision to limited to equiring cueing, assist to eat.  brinted 5/11/23, identified a eimer's disease, dementia with ance and generalized  ADS assessment dated severe cognitive impairment, ervision of one person physical  ated 4/9/23, identified a problem ormance of activities of daily endent with eating after set up. encouragement  brinted 5/11/23 indicated dimer's disease, diabetes entia with behavioral  ADS assessment dated 5/1/23 cognitive impairment and e assistance of one personal	F 5	both dignified and meets to this regulation. Appropriate are at the table with reside this definition and will stay they are finished with their Monitoring meal service would limited to, timeliness of ensuring appropriate mean for optimal enjoyment.  -Audits will be completed to per week for two (2) week per week for four (4) week thereafter for one (1) monited to results will be received at deficient practice will be indicorrected at the time of or ensuring or desire ponsible party.  -Corrective action will be completed to the time of or the time of the time of or the time of t	ely trained staff ents who meet with them until meal. will include, but is of service and I temperatures  s; two (2) times s; and monthly th. Audits QAPI. Any dentified and ccurrence.  signee is		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			TE SURVEY MPLETED	
		245473	B. WING		05/	C 11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
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F 550	a diagnoses of Alzh dementia with behand R3's annual MDS decognitive impairment one person physical R3's care plan date of daily living deficit setup and cues and During an interview stated there were on noon when she arriving the dining room to from the other nursistated there were the feeding at one table supervision and end stated "we needed today than we had" During interview on	ord, printed 5/11/23, identified reimer's disease, and revioral disturbance.  ated 3/1/23, indicated severe at and required supervision of a lassist with eating.  d 3/1/23 indicated an activities and requires supervision with assist as needed.  on 5/8/23, at 2:31 p.m., NA-A nly two NA's in the facility until ved. She called for assistance wice without any response ing staff members. NA-A wo residents that required and the other two require couragement to eat. NA-A more help in the dining room.		550		
	5/8/23, staffing was unaware the facility confirmed NA's wer assisting residents reheated when sitting Self-Determination CFR(s): 483.10(f)(1) §483.10(f) Self-determination The resident has the		F 5	561		6/30/23

245473  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET	/2023
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	
BAYSIDE MANOR LLC  GAYLORD, MN 55334	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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:  F 561  F 56	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245473	B. WING			C <b>11/2023</b>	
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP	<u>'</u>	11/2020	
DAVOIDI				640 THIRD STREET			
BAYSIDE	E MANOR LLC			GAYLORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 561	Continued From p	age 7	F 5	61			
F 561	two-person physic transfer, toilet use with dressing, person and wheelchair. Durinary incontinent (breakdown of joir bone), and heart for R28's care plan day (activity daily living r/t (related to) hear of the hips, trochabilateral primary of cognitive impairment, clean, and of staff; maintain currextensive A1 (assignooming, bathing NOC (night) shift, room around 6:00.  Progress note data information manage "Writer was helpin with resident to set to talk to someone get up early, between the set of the set of the hips, trochabilateral primary of cognitive impairment of the hip	cal assist with bed mobility, cone person physical assist sonal hygiene; utilized a walker iagnoses included: depression, ce, obesity, osteoarthritis of hip at cartilage and underlying ailure.  Ated 3/27/23, indicated ADL g) self-care performance deficit rt failure, bilateral osteoarthritis nteric bursitis left hip, obesity, steoarthritis of knee, and ent. Interventions included: dor free with assistance from rent level of function; and ist of one) with dressing, and eating. Get resident up on and prefers to be up in dining a.m.  ed 5/4/23 at 2:31 p.m., health gement (HIM)-F indicated, g check call lights and checked the what he needed. He wanted the about the fact that he wants to be en 5 and 5:30 and have a rhis care-plan. He was in bed at 10 and did not get to eat until to the fact that it has happened exently. Writer assured him that		this Plan of Correction doe an admission or agreement the facility of the truth of an or the correctness of any of forth in the allegations.  Accordingly, the Facility has submitted this Plan of Correctness of the under state and federal law submission of a Plan of Cotten (10) days of the survey to participate in Title 18 and programs. This Plan of Cotsubmitted as the facility's callegation of compliance.  -The process for satisfying requirement has been reviewed as needed, to ensure preferences are honored as implemented for rising.  -All residents who require a ADL's have the potential to the reviewed and revised as needed as needed and revised as needed as needed.	at of any kind by hy facts alleged conclusions set and section prior to all which may be requirements at that mandate prection within as a condition of Title 19 prection is credible.  This sewed and are resident and assistance with a be affected.  Sidents who L's was seeded to		
	the plan is followed and checked with needed. He wanted fact that he wants 5:30 and have bread the was in bed tod	appropriate people to ensure d was helping check call lights resident to see what he d to talk to someone about the to get up early, between 5 and akfast early per his care-plan. ay until at least 10 and did not 30 and eluded to the fact that it		-All necessary Bayside Ma providing direct care to res receive education on resident and where to locate this in care.	idents will ent preferences		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245473	B. WING _			C 11/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	11/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 561	has happened mor assured him that I is people to ensure the Progress note date licensed practical in stated "I want to get go out for breakfas make it on time."  Grievance summar had requested to go a.m., was still not use at 10:15 a.m., and Grievance indicated was placed on the to get up as it was early.  Grievance summar preferred assistance in the care plan to get the dining room and 5:30 a.m. Summary of action the care plan to get the dining room are considered assistance in bed until 10:00 at 10:0	e than once recently. Writer would notify the appropriate ie plan is followed."  d 4/27/23, at 6:50 p.m. urse (LPN)-B indicated, R28 it up early in the morning and it but I haven't been able to  y dated 1/23/23, indicated R28 et up between 6:00 and 7:00 p at 9:00 a.m., ate breakfast then was not hungry for lunch. It actions taken included R28 overnight aide list of residents R28's preference to get up  y dated 5/4/23, indicated R28 et to the dining room between and it was not happening. Taken indicated DON added to a R28 up on night shift and in bund 6:00 a.m.  p.m., R28 stated preferance ed shortly after 6:00 a.m. R28 bys of the week he was not e with morning cares and laid		-Education will be provided to Bayside Manor staff utilizing Nealthcare Policy and proced -Nursing and Social Services R28 to discuss rising preferencising preferences are update reflected on Kardex.  -Care plans and Kardex will be reflect preferences upon admupdated at least quarterly there.  -Audits will be provided two (2 week for two (3) weeks; one (week for (2) weeks; and mont thereafter for one (1) month. A will be reviewed at QAPI. Any practice will be identified and the time of the occurrence.  -Social Service Director or decresponsible party.  -Corrective action will be combefore 06/30/2023.	Monarch ure.  met with ces. R28s d and eafter.  It imes per hly hudit results deficient corrected at signee is		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING _		I	C 11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 561	rising time, expected the preferences.  Facility Policy titled Determination and indicated:  Policy Interpretation  1. Each resident is schedules and heal with his or her interests, values, as including: a. Daily routine, such eating, exercise and b. Personal care nemethods, grooming  2. In order to facilitate administration and a. Inform the residents' right is participation in prefeb. Gather information personal preference periodically thereafter, and doct the medical record. c. Include information resident's preference process; and d. Document and contact the medical record.	Quality of Life - Resident Self Participation dated 12/16,  In and Implementation  allowed to choose activities, lith care that are consistent  seessments and plans of care, lith cases and dress.  In a self-determination and lith cases and lith c	F 56	1		
	interfere with participation in pref Notify of Changes ( CFR(s): 483.10(g)(	Injury/Decline/Room, etc.)	F 58	0		6/30/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROF  DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	(i) A facility must improve consult with the responsistent with his consistent with his consults in injury and physician intervential (B) A significant characteristic characteristic characteristic complication (C) A need to alter the aneed to discontinutre treatment due to accommence a new form (D) A decision to transident from the fast (B) A decision to transident from the fast (C) (1) (ii) when making not (14) (i) of this section all pertinent informatis available and prophysician.  (iii) The facility must resident and the responsible to the consistency of the section (iv) The facility must update the address phone number of the consistency of	ification of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a Ith, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of liverse consequences, or to orm of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the t also promptly notify the sident representative, if any, m or roommate assignment 3.10(e)(6); or ident rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and	F 5	80		
	representative(s).					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING _			C <b>11/2023</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	Continued From pa	ige 11	F 58	30		
	Admission to a conthat is a composite §483.5) must disclusite physical configurations that compart, and must spectroom changes between the compart of the co	AT is not met as evidenced and document review, the vide the physician with all formation for a significant of 1 residents (R136) who otification of change.  Drinted on 5/10/23, indicated and included diagnoses of or surgery on the nervous fection of intervertebral disc grants muscle in the back) abscess, nic kidney disease.  Minimum Data Set (MDS) 3/10/23, indicated: R136 was ad adequate vision and ech, could understand and be required extensive assistance mobility, transfers, and		F580 s/s D:  Submission of this Response and Correction is not a legal admission deficiency exists or that this State Deficiency was correctly cited, and not to be construed as an admissifault by the facility, the Executive I or any employees, agents or other individuals who draft or may be dis in this Response and Plan of Correll In addition, preparation and submit this Plan of Correction does not coan admission or agreement of any the facility of the truth of any facts or the correctness of any conclusiforth in the allegations.  Accordingly, the Facility has prepasubmitted this Plan of Correction put the resolution of any appeal which filed solely because of the required under state and federal law that musubmission of a Plan of Correction ten (10) days of the survey as a coat to participate in Title 18 and Title 1 programs. This Plan of Correction	n that a ment of d is also on of Director rection. ission of onstitute alleged ons set and orior to may be ments and ate of within ondition 19	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	TIPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED
		245473	B. WING _			C <b>05/11/2023</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 640 THIRD STREET  GAYLORD, MN 55334	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATI	(X5) COMPLETION DATE
F 580	in cognition related Spanish speaking I was his own decision document changes.  R136 physician ord 3/3/23 - Ceftriaxond (treats infections), 2 daily for psoas abs 3/3/23 - Metformin 1000 mg twice a dablood sugar levels) 3/4/23 - Blood sugar bedtime four times mellitus).  3/27/23 - Obtain unrelated to burning varieded to burning varieder.  3/30/23 - UTI progradays.  3/30/23 - Levofloxatione tablet daily for During record reviet communications in Communication	R136 was at risk for alteration to diagnoses. R136 was put knew some English and on maker. Staff were to in orientation.  ers included: e, generic name for Rocephin, 2 gm (grams) intravenously cess, discitis. (anti-diabetic medication) ay for hyperglycemia (high ars before/after meals and a day for DM (diabetes)  ine sample for UA (urinalysis) with urination. Fax results to ess note every shift for 14  cin (treats infections) 500 mg, UTI for 14 days.  w, the following fax dicated:  a.m., a Fax indicated the last d a hard time starting flow of e bladder. Only small amount attempt using the urinal. Ing progress notes, this fax all provider (MP)-I the following p.m.). The same day e), a fax was received from	F 58	submitted as the facility's or allegation of compliance.  -The process for satisfying requirement has been revise as needed to ensure is provided all available clirinformation for a significant change in a resident.  -All residents in the facility potential to be affected if the is not met.  -All residents were reviewed to make necessary notifical physician.  - R136 has discharged from the image in a resident in the facility potential to be affected if the is not met.  -All residents were reviewed to make necessary notifical physician.  - R136 has discharged from the image in a resident.  - The facility QAPI team reversident in a resident.  - The facility QAPI team reversident in a resident.  - The facility QAPI team reversident in the image in a resident in a resident.  - The facility QAPI team reversident in a resident in a resident.  - The facility QAPI team reversident in a resident in a resident.  - The facility QAPI team reversident in a resident in a resident.  - The facility QAPI team reversident in a resident in a resident.  - The facility QAPI team reversident in a resident in a resident.  - The facility QAPI team reversident in a resident in a resident.  - The facility QAPI team reversident in a resident	this ewed and re a physicial fical the physical have the his requirement of the fical the physical change of the fical the physical change of the fical the physical change of the phys	ent ed 

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING			C 11/2023	
NAME OF PROVIDER OR  BAYSIDE MANOR LI				STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	11/2023	
PREFIX (EACH	DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
received f [illegible w prostatitis days was if no impro  Urinalysis indicated l including o (may indic kidneys ar blood cells dated 3/3  Progress sequence in which th of R136's possible w completely nursing st changes ir document back pain Progress nursing as together a provider.  Furthermo R136 repo resulted. N following f 1) 3/26/23 urination a 2) 3/27/23	(undeter rom MP-xord) findicated. For each back and back	mined time), a fax was J indicating the UA had some ngs for infection versus racin 500 mg once a day for 14 R139 was to follow up in clinic ated 3/28/23 and 3/29/23 rine had abnormal findings ne, positive for blood, ketones is too acidic), protein (a sign ed) and presence of white reteria. A urine culture (UC) ated no growth.  Icated, nurses documented a seriom 3/26/23 through 3/30/23 rined providers MP-I and MP-J rination, bladder pain and rention (difficulty urinating and reportion that had been gress notes, including nausea, and hallucinations.  Inot indicate a comprehensive reterior to the final UA being rogress notes indicated the		responsible partyCorrective action will be corbefore 6/30/23	npleted on or		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		245473	B. WING _		1	C <b>11/2023</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	burning with urinat 4) 3/27/23 at 3:43 for UA. 5) 3/27/23 at 3:56 an order for which catch or straight catch the UA was recatheterized specimen was obtained specimen was obtained the facilit not been ordered was Another UA would do a UC. 8) 3/29/23 at 1:27 informed the facilit not been ordered was Another UA would do a UC. 8) 3/29/23 at 1:20 obtained. 9) 3/30/23 at 8:18 delivered to the cliration of the cliration of the cliration of the contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute. During this contact with the Double of 1 increased respirate minute.	p.m., fax to MP-I regarding ion. p.m., order received from MP-J p.m., clinic was contacted for method to obtain the UA; clean ath (catheterization - inserting a a.m., 19 hours after the order eived, an order for a men was received. The ained and delivered to the lab p.m., a call from the lab y a UC was needed as one had with the initial UA order. need be obtained in order to p.m., a second UA was a.m., the urine specimen was				

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		245473	B. WING	j	0.5	C 5/11/2023
	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP C 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 580	diabetes complicati excess blood acids triggered by infection a larger hospital. On facility was informed R136 had passed at the larger hospital and the director of macknowledged the treatment for R136 delay was due to not wanting the provide method of obtaining catch or straight cardelay was partially a only a UA on 3/27/2 DON who was new timeframe, was away the hospital on 3/31 not been aware of the confusion and hallus addition to UTI sym of 3/26/23 to 3/30/23 to 3/30/23 to 3/26/23 to 3/	on where the body produces, or ketones and can be on) and would be transferred to a 3/31/23 at 7:30 p.m., the d by the larger hospital that away.  on 5/11/23, at 10:31 a.m., the a 3/26/23 to 3/30/23 was nal nurse consultant (RNC)-H aursing (DON). RNC-H are was a potential delay in RNC-H stated part of the arses being cautious and ar to order the preferred of the urine specimen - clean th. Further, RNC-H stated the attributed to MP-J ordering and not also a UC. The to her role during this are R136 was transferred to 1/23. However, the DON had he clinical changes of cinations R136 experienced in ptoms during the time frame	F &	580		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	· /	TE SURVEY MPLETED
		245473	B. WING		0.5	C / <b>11/2023</b>
	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	7 1 17 2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 580	telephone message MP-I, including pury date of birth, and renurse stated she we Intent of phone call 3/26/23 to 3/30/23 a 3/31/23.  During an interview licensed practical number day shift the week of involved in the direction involved with fax and between the facility UA. LPN-A did not licentacted a provide symptoms R136 has nausea, confusion at to abdominal pain a stated with multiple expected nursing stand characteristics including assessing possibly requesting (the amount of urinafter urination), assurine output, listentiand characteristics signs, and then confind information. LPN-A what I found and as anything prior to reddid not know why the During an interview RNC-H reaffirmed so nursing staff to notic symptoms were identification.	ge 16 s a.m., surveyor left a with clinic triage nurse for cose of call, R136's name, equested a call back. Triage could forward message to MP-I. was to discuss timeline from and rapid deterioration on  on 5/11/23 at 12:36 p.m., urse (LPN)-A who worked the of 3/26/23 to 3/30/23 was not ct care of R136, but was ad phone communication , MP-I and MP-J to obtain the know if nursing staff on duty er with the additional and hallucinations in addition and painful urination. LPN-A symptoms, she would have taff to conduct an assessment, an order for a residual urine the remaining in the bladder the ress R136's oral intake against to bowel sounds, assess color of R136's urine, assess vital thact a provider with that added, I would inform him the kif he wanted to initiate the ceiving the UA results. LPN-A his had not been done.  on 5/11/23 at 2:35 p.m., she would have expected fy a provider as soon as new entified the week of 3/26/23 to dicated that upon admission,		580		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG	` '	ATE SURVEY OMPLETED
		245473	B. WING			C 5/11/2023
	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP C 640 THIRD STREET GAYLORD, MN 55334	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 580	provider, MP-I, rath who regularly saw is stated most commit were conducted via On 5/11/23 at 4:44 second call to clinic earlier message haleave another messip.m., no return call On 5/11/23 at 5:00 survey, the DON provided the clinic of the	er than utilize the providers esidents at the facility. RNC-Hunication with MP-I and MP-J fax.  p.m., surveyor placed a for MP-I. Was informed the deen given; no need to sage. As of 5/15/23 at 4:00	F 5	80		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		COM	E SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334		
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F 677	delay incurred when UA in order to do a Facility policy titled Condition or Status would promptly noti provider of changes condition. The nurs attending physician had been a signification physical/emotional/notifying the physical nurse would make gather relevant and provider. Except in notifications would change occurring in condition or status. resident physical or comprehensive assecondition would be ADL Care Provided CFR(s): 483.24(a)(2) A resout activities of daily services to maintain personal and oral had the This REQUIREMENT by:  Based on observator review, the facility for residents receive as hygiene and activities.	delay was in addition to the in the lab requested a second UC.  Change in a Resident's and undated, indicated the facility fy the physician/health in the residents medical e would notify the residents or physician on-all when there and change in the residents mental condition. Prior to ian or healthcare provider, the detailed observations and pertinent information for the medical emergencies, be made within 24 hours of in the residents medical/mental. If a significant change in the mental condition occurred, a ressment of the residents conducted.  for Dependent Residents conducted.  for Dependent Residents  2)  ident who is unable to carry y living receives the necessary in good nutrition, grooming, and ygiene;  NT is not met as evidenced ion, interview and document ailed to ensure dependent esistance with personal es of daily living (ADL's) for 2 R15) who were dependent on	F 67		that a ent of is also	6/30/23

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION	` ′	E SURVEY PLETED
		245473	B. WING			C 11/2022
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/2023
	E MANOR LLC			640 THIRD STREET  GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (  (EACH CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APPORT (  DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	4/18/2023, indicate impairment; require with bed mobility, trand personal hygie rejected care behave pulmonary fibrosis tissue to scar, thick disease, anxiety, specification, and personal stemperson of the hips, depression, and R8's care plan date self-care performant pulmonary fibrosis, spinal stemperson of the claudication, osteodomentia; intervent (assist of one) with eating,); shower/bathospice, Saturday passistant).  R8's progress note refusal of care.  On 5/08/23 at 1:41 white and black chity (approximately ½ in her chin hairs shave)	mum Data Set (MDS) dated d: severe cognitive ed one-person physical assist ransfer, dressing, toilet use, ne; utilized a wheelchair; no viors. Diagnoses included: (lung disease that causes lung ten, and stiffen), Alzheimer's pinal stenosis of lumbar region audication (spinal nerves get lower spine), osteoarthritis of	F 6	fault by the facility, the Executivor any employees, agents or of individuals who draft or may be in this Response and Plan of Claraddition, preparation and sult this Plan of Correction does not an admission or agreement of the facility of the truth of any factor the correctness of any concliforth in the allegations.  Accordingly, the Facility has presubmitted this Plan of Correction the resolution of any appeal who filed solely because of the requirement and federal law that submission of a Plan of Correction (10) days of the survey as a to participate in Title 18 and Title programs. This Plan of Correct submitted as the facility's credit allegation of compliance.  -The process for satisfying this requirement has been reviewed revised as needed to ensure allegation of compliance.  -All residents in the facility have potential to be affected if this resistance with grooming, personal and oral hygiene tasks.  -R8 has been shaved. R15 recassistance with grooming, personal and grooming and grooming and grooming and grooming and grooming and gro	discussed orrection. In mission of constitute any kind by its alleged usions set in may be itements in mandate item within condition in condition in the sidents of the item its order in the item is one item is	
	seated in a wheelcl	2 a.m., R8 was observed hair, in the day room with long lursing assistant (NA)-A stated		-The plan of care for all resider require assistance with grooming		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245473	B. WING		05/11/	2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE C	(X5) OMPLETION DATE
F 677	shift.  On 5/10/23 at 10:14 (DON) stated shavi with morning cares observed. R8 told thair shaved. The Dwere long and need staff had not complement on 5/10/23 at 10:16 (TMA)-A stated state were expected to shair was visible. The provided R8 with more on staff assistance NA-C stated reside when long chin hair R15's quarterly Min 4/18/20/23, indicate impairment; require with bed mobility, dresonal hygiene, that transfer, and utilize included: heart failured.	A a.m., the director of nursing ng of residents was expected and when facial hair was he DON she wanted the facial ON confirmed R8's chin hairs ded shaving and confirmed eted the task for R8.  S a.m., trained medication aide of who provided morning cares have the residents when facial MA-A stated overnight shift orning cares.  2 p.m., NA-C stated night shift with facial hair removed. Into were expected shaved the swere visible.	F 67		eded to opriately or require all and iewed ducation the ene for times 2) times ally for after for elent	
	R15's care plan data self-care performandementia, heart fail resident will be near assistance from state	ed 5/10/23, indicated an ADL nce deficit r/t Alzheimer's, ure, COPD, weakness; t, clean and odor free with nff. Interventions included ressing and grooming;		-Corrective action will be complete before 6/30/23	ed on or	

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245473	B. WING			C 11/2023
	PROVIDER OR SUPPLIER  MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	after set up, ensure and eats slow.  On 5/08/23 at 9:35 and further indicate On 5/08/23 at 12:33 R15's room, chang R15 through the hadining room for lununaware if R15 was or ate breakfast. Not responsibility R15's On 5/08/23 at 3:48 had not provided R today and stated the caused staff to fall DON stated R15 w shower.  On 5/10/23 at 1:31 5/8/23, she arrived and R15's morning provided prior to he on 5/11/23 at 9:22 were expected to a cares. Residents w bed at 10:00 a.m.  On 5/11/23 at 9:48 bed under the covered on 5/11/23 at 10:35 (LPN)-A stated her	pathing; eating independent e out for meals to dining room, a.m., R15 was lying in bed ed had not eaten breakfast.  2 p.m., observed NA-C enter ed R15's brief and walked with allways and proceeded to the ch. NA-C stated she was a provided morning ADL cares A-C was unsure whose a morning cares were today.  p.m., the DON confirmed staff 15 morning cares or breakfast he disruption of the schedule behind with morning cares. as provided an afternoon  p.m., NA-A confirmed on at work around 12:00 p.m. cares nor breakfast had been er shift.  a.m., the DON stated staff sesist residents with morning ere not expected to still be in a.m., R15 was observed in her ers.  5 a.m., licensed practical nurse shift "just" started and a not assisted with breakfast or		77		

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245473	B. WING _			C <b>11/2023</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
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F 677	Continued From pa	age 22	F 67	77		
	not had time to contoday. NA-B stated	7 a.m., NA-B verified she had nplete R15's morning cares R15 was dependent on staff was expected to have had				
	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:					
	responsibility to creen environment that he each resident's quality across all shifts and principles of quality these principles for care and services and honor and sup	eate and sustain an umanizes and individualizes ality of life by ensuring all staff, d departments, understand the of life, and honor and support each resident; and that the provided are person-centered, port each resident's es, values and beliefs.				
	the following activity-bathing, dressing, Mobility-transfer and walking, c. Eliminatincluding meals and	rovide care and services for ies of daily living: a. Hygiene grooming, and oral care, b. d ambulation, including tion-toileting, d. Dining-eating, d snacks, e. Communication, n, ii. Language, and iii. Other iication systems.				
	of daily living will reto maintain good not personal and oral h	s unable to carry out activities eceive the necessary services utrition, grooming, and sygiene; and basic life support, en the resident requiring such				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	· /	E SURVEY IPLETED
		245473	B. WING			C <b>11/2023</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 684	emergency care primedical personnel physician orders and directives.	ge 23 or to the arrival of emergency and subject to related d the resident's advance		877		6/30/23
	S 483.25 Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a rethat residents recei accordance with propractice, the compressed on interview facility failed to importocol for 1 of 1 reconstipation.  Findings include:  R8's quarterly Minit 4/18/20/23, indicate impairment, require with bed mobility, trand personal hygie no rejected care be pulmonary fibrosis tissue to scar, thick disease, anxiety, specifications.	fundamental principle that eent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered esidents' choices.  NT is not met as evidenced and document review the lement bowel movement (BM) esident (R8) reviewed for mum Data Set (MDS) dated as evere cognitive and one-person physical assist ansfer, dressing, toilet use, ne, utilized a wheelchair, and haviors. Diagnoses included: (lung disease that causes lung en, and stiffen), Alzheimer's binal stenosis of lumbar region udication (spinal nerves get lower spine), osteoarthritis of ementia; and frequently		F684 s/s D:  Submission of this Response Correction is not a legal admodeficiency exists or that this Deficiency was correctly cite not to be construed as an action fault by the facility, the Exect or any employees, agents or individuals who draft or may in this Response and Plan or In addition, preparation and this Plan of Correction does an admission or agreement the facility of the truth of any or the correctness of any conforth in the allegations.  Accordingly, the Facility has submitted this Plan of Correction for the correctness of any conforth in the allegations.	Statement of d, and is also dmission of utive Director other be discussed f Correction. submission of not constitute of any kind by facts alleged nclusions set	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245473	B. WING		1	11/2023
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	•	11/2023
10 10 2	TO VIDER OIL GOIT EIER			640 THIRD STREET		
BAYSIDE	MANOR LLC			GAYLORD, MN 55334		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	HOULD BE	COMPLETION DATE
F 684	Continued From pa	age 24	F 6	84		
	R8's care plan date bowel and bladder included extensive upon rising, after not check/change on r	ed 4/7/23, indicated function incontinence and interventions assist of one, toilet resident neals, before bed,		the resolution of any appeal was filed solely because of the reconder state and federal law the submission of a Plan of Corrected (10) days of the survey as to participate in Title 18 and Topograms. This Plan of Corrected submitted as the facility's cree allegation of compliance.	quirements nat mandate ection within a condition itle 19 ection is	
		m. large, formed bowel		-The process for satisfying th	is	
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.			requirement has been review revised as needed to ensure being monitored for having removements and that there are interventions in place to treat constipation is indicated.	residents are gular bowel e appropriate		
	4/9/23, no bowel m 4/10/23, no bowel 4/11/23, no bowel	novement movement movement		-All residents in the facility had potential to be affected if this is not met.		
	4/12/23, no bowel movement. (5th day) 4/14/23, 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.			- R8 has bowel movements no daily and standing orders are direct staff on how to treat if the bowel movement for 3 days.	in place that	
				-All residents' bowel moveme monitored daily and have star in place to direct staff on how	nding orders	
				there is no bowel movement to -Necessary staff have received	ed education	
		p.m., R8 was seated in a licated problems with		on the process of monitoring movements and how to treat		
	wheelchair and indicated problems with constipation. R8 was not able to discuss more specifics related to bowel movements or constipation.			-The facility QAPI team review CMS-2567 and POC during the 2023 meeting.		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473			05/11/2023		
	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	1 00/		
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F 684	Continued From pa	ige 25	F 6	84			
	(NA)-C confirmed a responsible for recombined BM. NA-C stated the monitor resident's I on 5/10/23 at 6:53 (LPN)-D confirmed when a resident had awas nursing's responsible for reviresident had awas followed the standing LPN-D stated the movement, staff of the resident had awas followed the standing LPN-D stated the movement and passed day staff.  On 5/10/23 at 6:33 DON verified R8 was six days per the dorecord with no bow further verified no strelieving medication DON stated resident management were orders. The DON stated nursing judgestated nursing judgestated nursing judgestated nursing judgestated stated nursing judgestated nursing	B a.m., nursing assistant all direct care staff were ording when a resident had a ne nurse was responsible to cowel movements.  p.m., licensed practical nurse NA's and nursing charted d a bowel movement and it consibility to monitor. Further, ent three days without a bowel fered prune juice or whatever railable as needed and and bowel protocol orders. The bowel protocol orders without a bowel with the information on to the ed the information on to the ent four days, five days, and cumentation of R8's medical el movement. The DON stool softeners or constipation as were given per the MAR. Ints' expectations for bowel nursing to follow the standing tated the facility's bowel ling orders did not specify the owel program. The DON ement was expected to initiate ant and documentation related		-Audits will be completed three (per week for two (2) weeks; two per week for two (2) weeks; weetwo (2) weeks; and monthly ther one (1) month. Audit results will reviewed at QAPI, with any deficient practice corrected at the time of occurrence.  -Director of Nursing or designeer responsible party.  -Corrective action will be completed before 6/30/23	(2) times ekly for eafter for be cient		
	to the bowel intervented standing orders we nursing after resident after three days, do assessment, or resident.	entions. The DON confirmed re expected initiated by ents with no bowel movement					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245473		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED  C 05/11/2023		
		B. WING _				
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	forward the standing to initiate the bowel facility policy titled, indicated:  Policy: all residents monitored for signs Constipation and repharmacological information and reph	The DON stated going g orders would specify the day program  Bowel Program dated 5/23,  at Bayside Manor will be and symptoms of eceive adequate dietary and tervention to ensure bowel  empt to utilize dietary products a Manor as means of the following are available for the following are available for the sures are ineffective to relieve ill use the following:  30 CC orally up to BID PRN for the avoid if on dialysis) if not	F 68	34		
	Constipation if not each of a constipation of the above laxard week contact the other interventions and order	tives/suppositories are used x residents MD for order. Any will require physician contact  Prevent/Heal Pressure Ulcer	F 68	36		6/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245473	B. WING _		05/11/2023	
	PROVIDER OR SUPPLIER E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
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F 686	resident, the facility (i) A resident receive professional stands pressure ulcers and ulcers unless the indemonstrates that to demonstrates from describing the sessional stands and stands and the sessional stands are demonstrated to demential the sessional stands are demonstrated to demential the sessional stands are demonstrated to demonstrate the sessional stands are demonstrated to demonstrated to demonstrate the sessional stands are demonstrated to demonstrate the sessional stands are demonstrated to demonstrated the sessional stands are demonstrated to demonstrate the sessi	egrity sure ulcers.  orehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure adividual's clinical condition they were unavoidable; and oressure ulcers receives and services, consistent candards of practice, to revent infection and prevent veloping.  NT is not met as evidenced  tion, interview and document ailed to comprehensively pressure ulcer (PU) for 1 of 1 was diagnosed with pressure -admission from the hospital.  rinted 5/11/23, included the of neck of left femur, (lung tissue scars, thickens are of left pubis (pelvic bone), f ribs right side, heart failure, m (abnormal growth of tissue)	F 6	F686 s/s D:  Submission of this Response and Correction is not a legal admission deficiency exists or that this Stater Deficiency was correctly cited, and not to be construed as an admission fault by the facility, the Executive Dor any employees, agents or other individuals who draft or may be dis in this Response and Plan of Correction addition, preparation and submit this Plan of Correction does not coan admission or agreement of any the facility of the truth of any facts or the correctness of any conclusion forth in the allegations.  Accordingly, the Facility has preparate submitted this Plan of Correction put the resolution of any appeal which filed solely because of the requirer under state and federal law that metallic solely because of the requirement of t	that a ment of dis also on of Cirector section. It is section to may be ments	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NI IMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245473	<b>245473</b> B. WING		05/11/2023		
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C	•	11/2020	
D AVOID F				640 THIRD STREET			
BAYSIDE	E MANOR LLC			GAYLORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	Continued From p	age 28	F 6	86			
	-	ut had no skin issues currently.		submission of a Plan of Cor	rection within		
		, , , , , , , , , , , , , , , , , , ,		ten (10) days of the survey			
		e plan dated 2/2/23, last revised		to participate in Title 18 and			
	•	pairment to skin integrity related		programs. This Plan of Cor			
		coccyx wound related to minal illness and fragile skin.		submitted as the facility's cr allegation of compliance.	ealble		
		ded: turn and reposition every		allegation of compliance.			
	2-3 hours, encourage good nutrition and			-The process for satisfying t	this		
	hydration in order to promote healthier skin,			requirement has been revie	wed and		
	identify/document potential causative factors and			revised as needed to ensure			
		where possible. Follow facility		admitted to the facility have			
	protocols for treatr	nent of injury.		comprehensive skin assess completed at the time of ad			
	An Incident Review	w and Analysis form dated		oomploted at the time of ad	THOOICH.		
		mately 2:30 a.m., indicated		-All residents who are admit	ted to the		
	R21 was found on the floor in her bathroom on			facility have the potential to			
		ack. R21 was transferred to		this requirement is not met.			
		partment (ED) via ambulance diagnosis of left femur fracture.		- R21 has not discharged or	r transforred		
		e facility on 2/2/23, with		out of the facility. A comprel			
	hospice services.			assessment has been comp			
	A hospital dischar	ge summary dated 2/2/23,		-All residents have a compr	ehensive skin		
		diagnosis of fracture of neck of		assessment completed.			
	•	problems listed as renal mass,					
		requent falls. R21 had surgical		-Necessary staff have recei			
		30/23. Recovery was creased confusion and rapid		on completing a compreher assessment upon admissio			
	'	scussion with the family,		readmission to the facility.	ii aiia		
		and comfort care was		<b>,</b>			
	implemented upor	n discharge.		-The facility QAPI team revi			
	D041 D : " -			CMS-2567 and POC during	the June		
		ita Collection form dated 2/2/23		2023 meeting.			
		licensed practical nurse a.m., indicated a change in		-Audits will be completed th	ree (3) times		
		ctivities of daily living (ADL)		per week for two (2) weeks;	` '		
		Foley catheter in place. Skin		per week for two (2) weeks;	<b>\</b> /		
	assessment include	ded left trochanter (hip) surgical		two (2) weeks; and monthly	thereafter for		
incision intact with 15 staples face with several			one (1) month Audit results	will be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245473		` IDENTIFICATION NI IMBER:   ` ` `		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING			C 05/11/2023		
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC				STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	with several bruises Collection form lack injury. Further, the comprehsive skin at time of re-admission A progress note dar (MP)-L, indicated R surgical repair on 1 significant delirium hospice upon return R21 had been lethat time. R21 had been lethat time. R21 had no ratexposed skin. Has hip incision with no Anticipate progress focused care.  R21's weekly skin in registered nurse (Rather the coccyx area and buttock, 2.0 x 2.6 cm buttoc	elated to fall and bilateral arms is noted. The Readmit Data ked evidence of deep tissue record lacked evidence a assessment was completed at ion.  Ited 2/7/23, by medical provider 21 had left hip fracture with /30/23. R21 experienced post-op and was enrolled in a back to the facility on 2/2/23. Eargic and sleeping most of the ashes, wounds or lesions to extensive facial bruising, left redness or drainage. Sive decline with comfort  Inspection on 2/8/23, by 2N)-A removed a mepliex from d noted a blister on left m, with abrasion on left lower m. Unstageable purple area accyx (most distal portion of the buttock has a 2.6 x 1.0 cm buttock had an area of	F 68	reviewed at QAPI, with any operactice corrected at the time occurrence.  -Director of Nursing or designesponsible party.  -Corrective action will be combefore 6/30/23	e of nee is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING _			C /11/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 686	Continued From pa	ge 30	F 68	86			
	•	pale red made of serum and cally seen as wound is trying to ed.					
	indicated coccyx wi unstageable 6 x 4 x (layer of dead tissue included wound bed noted yellowish slow appearance. Provide orders for wound catalginate silver to we silicone foam border and as needed.	e) present. Description d was grayish slough with ugh around edges. Moist in ler was updated with new are. MP-M to place calcium ound bed and cover with er dressing three times a week ultant progress note dated					
	•	cated coccyx pressure ulcer x 0 with light serosanguinous					
	indicated unstageal	form dated 2/22/23, LPN-A ble coccyx wound 11 x 8 x 0 0% necrotic with light ainage.					
	indicated stage 4 comproving. Wound undermining presendrainage. 35% necongranulation. No borfree of slough, necomuscle/fascia level						
		and measurements continued ng wound MP-M and LPN-A ng.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION  ING	` '	(X3) DATE SURVEY COMPLETED	
		245473	B. WING	i	0.4	C 5/11/2023	
	PROVIDER OR SUPPLIER E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP C 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	71172020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 686	dated 5/4/23, MP-M remain in place. For tissue injury evolved Wound was improved 0.7 x 1.2. Moderate continued with 1000 exposed but no bor improve week over.  Most recent wound indicated a stage 4 0.7 x 0.3 with 100% healing, no bone extend and no pain noted. cleanse with Vashe gauze and allow to minutes with each of prep to wound edge calcium alginate. Concept development of prep 5/8/23. R21 was ideal of the continued on her left sit on the bed.  Observation on 5/1 taken back to her reservation on 5/1 taken back to her re	ting wound care progress note I indicated hospice services flow up management of deep d to stage 4 pressure ulcer. Fing with measurements of 3 x serosanguinous drainage % granulation with muscle he. Wound continued to		586			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245473	B. WING			C 05/11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	hollering out for help bed. The director of assistant (NA) responses transferred back common room. R21 common room until assisted R21 back changed and settled linterview on 5/10/23 she assessed the way upon return and assisted a complete skin confirmed she did ray upon return so was was present on admitted with a sore dressing was present admitted with a sore dressing was present epositioning her evinitially returned. Not every 2 hours.  Interview on 5/11/23 indicated she wasn't her coccyx or dress returned from the hormally worked nigrepositioning R21 expositioning R21 expositioning R21 exposition upon the process of the skin inspection upon the skin i	D/23, at 4:43 p.m. R21 was p and began to climb out of finursing (DON) and nursing onded immediately and R21 ck to her chair and out to the firemained in wheelchair in 6:15 p.m. when an aide to her room, checked and dinto bed on her right side.  3, at 3:30 p.m., LPN-A stated younds she could visualize sumed the nursing staff would check upon admission. LPN-A not observe the coccyx area unsure if deep tissue injury mission or not.  3, at 10:20 a.m., NA-C of the remember if R21 was the on her coccyx or if a cent. NA-C added they were seen they are doing at least at 10:40 a.m., NA-B of they are doing at least they are doing at least they were seen they are doing at least they are she ospital. NA-B added she opht shift and they were	F 6	86		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		245473	B. WING _		l	C 11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	registered nurse (Rethe admission nurse R21's record and in documentation there documentation presentation includes a surgical incit Documentation includes and on admission.  Interview on 5/12/2 she was not sure if the wound present admission. MP-L at the health condition to say if the wound facility or if it was provided a surgical to say if the wound facility or if it was provided and procedured for every (Braden Scale).  A Skin Assessment policy and procedured for every (Braden Scale).  Staff will perform redaily care.  Nurses are to be not identified.  A weekly skin inspection.			36		
<b>F 688</b> SS=D	licensed staff. Increase/Prevent D CFR(s): 483.25(c)(	ecrease in ROM/Mobility 1)-(3)	F 68	38		6/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245473	B. WING _		1	C <b>11/2023</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	03/11/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 688	resident who enters range of motion do range of motion un condition demonstr of motion is unavoid §483.25(c)(2) A resmotion receives apservices to increase prevent further dec §483.25(c)(3) A respectives appropriate assistance to mainst the maximum practive reduction in mobility. This REQUIREMED by:  Based on interview review, the facility for walking program to 1 of 1 residents (Reservices.  Findings include:  R12's face sheet prodiagnoses of cereby that impact the blood dayarthria (speech weakness of the modiabetes mellitus weakness of the modiabetes mellitus weakness of and weakness of the modiabetes mellitus weakness of and weakness of the modiabetes mellitus weakne	facility must ensure that a sthe facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range dable; and sident with limited range of propriate treatment and erange of motion and/or to rease in range of motion.  Sident with limited mobility reservices, equipment, and tain or improve mobility with sicable independence unless a yis demonstrably unavoidable. Not is not met as evidenced or, observation and document ailed to ensure staff provided meet the assessed needs for 12) reviewed for restorative rinted on 5/11/23, indicated rovascular disease (conditions of vessels in the brain) with disorder cause by paralysis or uscles of the mouth) and miparesis (paralysis), type 2 ith neuropathy (nerve	F 68	F688 s/s D:  Submission of this Response Correction is not a legal admis deficiency exists or that this Si Deficiency was correctly cited, not to be construed as an adm fault by the facility, the Executior any employees, agents or cindividuals who draft or may be in this Response and Plan of In addition, preparation and suthis Plan of Correction does not an admission or agreement of the facility of the truth of any facility of the truth of any facility of the allegations.  Accordingly, the Facility has p	tatement of and is also also nission of ive Director ther discussed Correction. Ubmission of any kind by acts alleged clusions set		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION  NG	1 ` ′	(X3) DATE SURVEY COMPLETED	
		245473	B. WING			C 11/2023	
NAME OF I	PROVIDER OR SUPPLIER		l 	STREET ADDRESS, CITY, STATE, ZIP C	· · · · · · · · · · · · · · · · · · ·	11/2020	
DAVCIDE	E MANOD LLC			640 THIRD STREET			
DATSIDE	E MANOR LLC			GAYLORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 688	Continued From pa	age 35	F 6	88			
	rejection of care and dressing, personal transfers. Walking R12's care plan day activities of daily live and required mining walker for transfers ambulation. R12 wheelchair to follow	e deficit, no behaviors including and extensive assist of one for hygiene, toileting and on and off unit did not occur.  Ited 4/3/23, indicated an ving (ADL) performance deficit nal assist of 1 with gait belt and s, moderate assist of 1 for vas to ambulate 2 times daily ront wheel walker with w behind (2 people). Support the 4 wheeled walker.		submitted this Plan of Corrective resolution of any appeal filed solely because of the reunder state and federal law submission of a Plan of Corten (10) days of the survey a to participate in Title 18 and programs. This Plan of Corsubmitted as the facility's crallegation of compliance.  -The process for satisfying to requirement has been reviewed.	which may be equirements that mandate rection within as a condition Title 19 rection is edible this wed and		
	stated when she find walk with one foot, stated she would list staff don't take her	rst got to the facility she could but now she was to weak. R12 ke to walk in the hallway but for a walk. R12 added she erapy related to weakness from infection.		revised as needed to ensure who require a restorative probeen developed and is being by staff.  -All residents in the facility has potential to be affected if this is not met.	ogram has g carried out have the		
	(FM)-C stated staf	at 2:31 p.m., family member f were not walking R12 as her and staff had indicated it		- R12 is currently in therapy ambulation program is in the being developed with Physic	e process of cal therapy.		
	was in her wheelch herself to the dinin			-All residents that are in Occ Physical and Speech therap restorative program develop and staff will carry out restorate as appropriate.	by will have a bed if indicated		
	her wheelchair in he did not work with he walked her.	0/23 at 4:06 p.m., R12 was in er room. R12 stated therapy er today and no staff had		- NAR guides for all residen restorative programs in place reviewed to ensure there are instructions on how to carry	e have been e clear		
	was in the dining re	on 5/10/23 at 6:20 p.m., R12 com and wheeled self back to the bathroom, R12 came out of		restorative program.  -Necessary staff have received	ved education		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245473	B. WING _			C 11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 688	in her room in her ventered room, assist and then watched to the Interview on 5/10/2 R12 was currently it ask her to walk at a the facility all day a walk R12" even the recommended it in also told her staff do the	minutes later and was sitting wheelchair. At 7:17 p.m., staff sted R12 into her pajamas, elevision from her wheelchair.  3 at 1:53 p.m., FM-D stated n therapy because staff "never all". FM-D added she was at nd had "never once seen staff bugh therapy had the past. FM-D stated R12 o not walk her.  ted 3/2/23 at 5:14 p.m., urse (LPN)-A indicated from therapy were received mobility, minimal assist of one. assist of 1 with gait belt and , assist of one with use of gait led walker (FWW) with w, to tolerance. Remind to ort right hand on FWW.  Recommendations form ated ambulation to occur two assist of 1, wheelchair to follow n, gait belt and front wheeled and remind to stand tall,	F 68	on the process for communitherapy to nursing of restoral when one is developed.  -Necessary staff have been the expectations of carrying restorative programs as developed.  -The facility QAPI team reviet CMS-2567 and POC during 2023 meeting.  -Audits will be completed through per week for two (2) weeks; two (2) weeks; two (2) weeks; and monthly one (1) month. Audit results reviewed at QAPI, with any operactice corrected at the time occurrence.  -Director of Nursing or design responsible party.  -Corrective action will be combefore 6/30/23	educated on out eloped by  ewed the the June  ee (3) times two (2) times weekly for thereafter for will be deficient e of	

NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC  STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, NN 55334  SUPPLIES THE STREET GAYLORD, NN 55334  CONTINUED FROM STATE PROVIDER OF AUST SEPECCEDES POLL, EXCHIDENCE OF THE APPROPRIATE OF DEPLOYENCE OF PULL (EXCHIDENCE OF THE APPROPRIATE OF DEPLOYENCE OF THE APPROPRIATE OF THE APPROPR	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	l \ /	(X3) DATE SURVEY COMPLETED	
BAYSIDE MANOR LLC  BAYSIDE MANOR LLC  SUMMARY STATEMENT OF DEFICIENCIES (ATLANDRESS, CITY, STATE, ZIP CODE 400 THIRD STREET GAYLORD, MN 55334  FREETLANDRESS, CITY, STATE, ZIP CODE (ACC) THE APPROPRIATE COME (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 688  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 aid (P/TA)-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			245473	B. WING _		0.5	C 5/11/2023	
FREEIX TAG  REGULATORY OR LSc IDENTIFYING INFORMATION)  F 688  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 9:05 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 nassist 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					640 THIRD STREET	<u> </u>		
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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION	
were walking R12 at all since she was admitted,	F 688	FWW and wheelch for transfers.  Review of point of 3/3/23 through 4/16 Walk in hallway: Nout of possible 90 at times requiring limit Walk in room: NA attempts. Walking a limited to extensive limited	care ambulation record from 6/23, included: ot applicable (NA) 86 times attempts. Walking occurred 4 ted to extensive assistance. 87 times out of possible 90 occurred 3 times requiring assistance.  rvation on 5/11/23 at 8:57 te dining room eating breakfast R12 used one leg to wheel self R12 stated she wanted to walk was in the wheelchair too when she came to the facility or and now she doesn't at all this wheelchair.  1.5/11/23 at 9:04 a.m., NA-C alked R12 in the past but working with therapy and were as at 9:06 a.m., physical te stated therapy started fter she had Covid-19 on icated she was an assist of 2 s currently in between 1 and 2 d R12 was supposed to be on prior to this and if staff were by should have been.  3. at 10:38 a.m., nursing ated she did not think they		38			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING _			C 11/2023	
	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334	1 00/		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	Continued From pa	ge 38	F 68	8			
	nursing (DON) state on the desk and whathere shortly after send of March, asked staff were unsure. The process was put into by the interdisciplination for realistic expectation was state and added to tasks expectation was state and when resident either the nurse or the A policy and proced requested and none free of Accident Harch (S): 483.25(d) (1) The facility must en §483.25(d) (1) The facility must en §483.25(d) (2) Each supervision and assaccidents. This REQUIREMENT by:  Based on interview facility failed to come 6 residents reviewed.	azards/Supervision/Devices 1)(2)  ats.  asure that - resident environment remains hazards as is possible; and  resident receives adequate sistance devices to prevent  NT is not met as evidenced  v, and record review, the aprehensively assess 1 (R9) of ed for falls, for safe use of ed, including independent use of air.	F 68	F689 s/s D:  Submission of this Response and R Correction is not a legal admission deficiency exists or that this Statem Deficiency was correctly cited, and	that a nent of	6/30/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			
		245473	B. WING			05/1	1/2023
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DAVOIDE				64	0 THIRD STREET		
BAYSIDE	MANOR LLC			G/	AYLORD, MN 55334		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION DATE
F 689	Continued From pa	ige 39	F 6	889			
	R9's face sheet prir	nted 5/11/23, indicated			not to be construed as an admission	n of	
	•	g, hemiplegia and hemiparesis			fault by the facility, the Executive D	irector	
	(weakness or paral	ysis on one side of the body)			or any employees, agents or other		
	_	nfarction (stroke) affecting			individuals who draft or may be disc		
		, vascular dementia (problems			in this Response and Plan of Corre		
		nning, judgment, memory and			In addition, preparation and submis		
	thought processes)				this Plan of Correction does not con		
		ng term use of anticoagulants			an admission or agreement of any	•	
	(medication that inr	nibits coagulation of the blood).			the facility of the truth of any facts a	•	
	PO's quartarly Minir	num Data Set (MDS) dated			or the correctness of any conclusio forth in the allegations.	ns set	
		usually understands and is			iorui iii ule allegalions.		
	,	cognitive impairment, has			Accordingly, the Facility has prepar	ed and	
		n anticoagulant and diuretic.			submitted this Plan of Correction p		
		ing (ADL's) included extensive			the resolution of any appeal which		
		person for locomotion,			filed solely because of the requirem	nents	
	personal hygiene, c	dressing and toileting.			under state and federal law that ma	ndate	
					submission of a Plan of Correction		
		sment completed 9/15/21,			ten (10) days of the survey as a co		
		score of 17, high fall risk. The			to participate in Title 18 and Title 19		
		tion was completed on			programs. This Plan of Correction	İS	
	-	cated R9 was at a potential risk			submitted as the facility's credible		
		to functional and cognitive ice 10/8/22. Will continue to			allegation of compliance.		
	monitor resident's s				-The process for satisfying this		
	Thornton resident 3 s	baicty.			requirement has been reviewed an	d	
	A facility Event Rep	ort dated 10/10/22 at 5:09			revised as needed to ensure reside		
		had a fall from chair or			safely utilizing equipment, including		
		/22 at 5:45 a.m. Causal factor			electric lift chairs.		
	for the incident incl	uded R9 was sitting in her					
		n. Staff heard resident call out			-All residents in the facility who use		
	-	ering resident's room, staff			electric lift chairs have been assess		
		was sitting on the floor with her			safety. All residents who have elect		
		d and her upper body was			chairs in their rooms have been ass	sessed	
		foot of the recliner which was			as safe to have.		
	extended out. No in	,			D0 has been seesed for a few		
	_	s included hemiplegia nd			- R9 has been assessed for safe us		
		ng cerebral infarction affecting side. Medications included			the electric recliner. It was determined was not safe to use independently,		

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		245473	B. WING _		05/1	1/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	1 00, 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	forming). Interventional material) to chair of R9's plan of care day potential risk for fall falls. Interventions is resident falls to det can be addressed, soaker pad to help keep common used to recliner after me wear proper and not R9's care plan date falls related to alter decreased safety a impairment. Interventies and follow facility falls and follow facility falls. During interview on 3-5 times per shift of and follow facility falls. During interview on not remember any her electric recliner. Interview on 5/10/2 practical nurse (LP) her own chair but for elevated the chair of the record. She was assessment with the	ent serious blood clots from ons included Dysem (non slip wheelchair.  ated 11/10/22, indicated a ls characterized by history of ncluded: analyse previous ermine whether pattern/trend dycem placed in recliner over prevent resident from sliding, d articles within reach, transfer als per request and resident to onslip footwear.  ad 4/20/23, indicated at risk for ation in mobility and wareness related to cognitive entions included: call light to be on person, check on resident while positive for Covid-19, all protocol.  5/8/23 at 11:41 a.m., R9 did falls at the facility or fall from or some unknown reason up and it kept going until she. LPN-A stated she reviewed is unable to locate a safety e electric recliner chair and	F 68		eted for cliner ectric in resident afe has lectric te new larterly, the June for four puarters will be ent is	
	Interview on 5/10/2 (SS)-A stated she was member with conce	as last assessed for safety.  3 at 4:58 p.m., social services was contacted by a family erns related to R9 being in a ning the fall occurred. R9 was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	l \ /	(X3) DATE SURVEY COMPLETED	
		245473	B. WING		05	C /11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	11/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 689	been elevated and R9 was not able to stated her and (LPN assessments in the an electric recliner to locate when R9 was not able to locate when R9 was lectric recliners. The reviewed R9's plan of the dycem as should be assessed price and quarterly thereas and quart	e recliner and the recliner had tipped to the standing position. recollect the incident. SS-A N)-A had completed past for safety with the use of but upon request was not able was last assessed.  3 at 1:08 p.m., the director of ed the facility had an ctric chairs, which should be months for residents who have the DON added she recently of care and discontinued use e felt it was outdated. The electric chair should have or to the fall, immediately after, after.  Ind Management policy last uded: I or probable fall, the staff will the fall, such as when the fall occurred and what the g to do at the time the fall egin to try to identify possible the incident. Chains of events or ceding a recent fall, including, he resident was doing or hether the resident was reaching or transferring from the staff or try to identify possible the incident.		689		
	morning meeting.					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  IG	COMPLETED		
		245473	B. WING _		1	C 11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334		
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F 689	information until the falling or determine found.  -Avoidable accident occurred because environmental hazeresident risk of an supervision and/or evaluate/analyze them, if possible, or implement measure as much as possible.  A policy on Electrical 12/2019 included:  -The facility will make identify the potential each resident.  -Licensed staff, the interdisciplinary teacomprehensive evaluate/analyze the residents plainstructions for safely use the residents plainstructions for safe is not limited to, resposition the chair and be necessary if the recliner chair is unside the resident can lift chair safety, the reviewed and documents.	nue to collect and evaluate ey either identify the cause of a that the cause can not be at means that the accident the facility failed to: Identify ards and or assess individual accident, including the need for assistive devices; and or ne hazards/risks and eliminate or if not possibly, identify and es to reduce the hazards/risks ale.  Lift Chair Recliners dated alke a reasonable effort to all hazards and risk factors for erapy personnel, and/or the am, will complete a aluation of the resident's ability ecliner lift chair. In of care will include specific e use which could include, but sident's access to controls and and/or resident should be left in. Iternative safety measures may evaluation determines the		9		
<b>F 698</b> SS=D	provider as application Dialysis CFR(s): 483.25(l)	ble.	F 69	8		6/30/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		1 ` ′	(X3) DATE SURVEY COMPLETED	
		245473	B. WING		05/11/2023		
	PROVIDER OR SUPPLIER E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP 640 THIRD STREET GAYLORD, MN 55334	CODE		
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F 698	require dialysis rec with professional st comprehensive per the residents' goals This REQUIREMED by: Based on interview facility failed to have ongoing communicated and obtain a writtenthe dialysis provided residents (R10) rewelling include: R10's face sheet per diagnosis of end st diabetes mellitus were disease. R10's quarterly Min 2/8/23, identified Resident needed her indwelling catheter 1 for toilet use. R10's care plan day resident needed her failure. Intervention dialysis Monday, We time started at 8:30 arrived at 7:50 a.m. listed. On 5/10/23 at 4:32 director (ROD) indiccontract or agreement	nsure that residents who eive such services, consistent tandards of practice, the reson-centered care plan, and and preferences.  NT is not met as evidenced wand document review the e a coordinated plan with eation for dialysis treatments in contract/agreement between er and the facility for 1 of 1	F 6	F698 s/s D  Submission of this Respond Correction is not a legal and deficiency exists or that this Deficiency was correctly contour to be construed as an afault by the facility, the Execor any employees, agents individuals who draft or main this Response and Plan In addition, preparation and this Plan of Correction does an admission or agreement the facility of the truth of an or the correctness of any contour the resolution of any appearance of the under state and federal law submission of a Plan of Cotten (10) days of the survey to participate in Title 18 and programs. This Plan of Cotsubmitted as the facility's coallegation of compliance.	dmission that a is Statement of ited, and is also admission of ecutive Director or other ay be discussed of Correction. It of any kind by my facts alleged conclusions set as prepared and rection prior to all which may be requirements by that mandate or rection within as a condition of Title 19 or rection is credible		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245473	B. WING		C 05/11/2023	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	1/2020
RAYSIDE	MANOR LLC			640 THIRD STREET		
DATOIDE				GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 698	Continued From pa	ige 44	F 698	8		
	was located.	previous name and no contract  3 at 2:00 p.m., licensed		requirement has been reviewed a revised as needed, to ensure ther agreement in place and a coordinate plan with communication for any respectively.	e is an ated	
	· ·	N)-C stated the facility sent a ord with R10 but sometimes		receiving such services.		
	•	was not completed and sent		- All residents residing in the facilit		
	today (5/10/23) with communication form	m, dialysis run information		received dialysis services have the potential to be affected if this requise not met.		
	including vital signs	s, and pre and post weights.		- Facility will ensure a written dialy	rsis	
	practical nurse (LP	3 at 2:00 p.m., licensed N)-A stated the facility has not rvices or plan of care with the		agreement is in place for all reside receiving dialysis.		
		N-A added they (dialysis		- The plan of care for R10 was rev		
	• <i>'</i>	good at communicating and to call to get the information reatments.		and revised as needed to ensure twas no harm or lasting effects.	there	
	L. 1	0 4 0 0 5		- The facility immediately initiated		
		3 at 2:05 p.m., director of firmed the facility lacked		conversation with the dialysis cent obtained an agreement, which wa		
	_ ` ` ` `	es with the dialysis facility and		provided prior to survey exit. This		
	The DON stated sh	et post dialysis information. le became aware after the t was requested that there		completed and will not expire unle either party agrees.	ess	
	wasn't one.	i was requested that there		- The facility will leverage the com agreement to ensure communicat	•	
	A policy for Hemod	ialysis dated 11/22/19,		collaboration with the dialysis cent	ter.	
	included:	ad the dielycie center will beyo		Bayside Manor staff have been ed		
		nd the dialysis center will have ation and collaboration are and services.		using Monarch Healthcare Manag policy and procedure on Hemodia		
	-The facility should	communicate, facilitate, and		- Audits will be completed three (3	,	
		dialysis team regarding a plan		per week for two (2) weeks; two (2)	,	
	needs.	n interventions and toileting		per week for two (2) weeks; one ( per week for one (1) week; and m	,	
		and from the dialysis center will		thereafter for one (1) month. Aud	•	
	•	cording to the dialysis contract		will be reviewed at QAPI, with any		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING		05/	C 11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	1 001	
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F 725	dialysis center.  -Ongoing communithe development and dialysis plan of care facility and dialysis.  -Communication should dialysis provider catter resident's response medications administresults, the resident condition or mood, access site.  -If run information is resident upon return dialysis unit to obtain with obtaining dialysto the DON and/or Sufficient Nursing SCFR(s): 483.35(a) (SSASSASSASSASSASSASSASSASSASSASSASSASSA	cation and collaboration for and implementation of the should be maintained by the team. Hared between the facility and in include, but is not limited to onse to the dialysis treatment, astered, labs drawn and their t's end weight, changes in and the evaluation of the short received with the information. Problems in the information will be reported the medical director. Staff 1)(2)		deficient practice corrected at the occurrence.  - DON or designee is responsible  - Corrective action will be complet before 6/30/23	party.	6/30/23
	by sufficient number types of personnel	facility must provide services rs of each of the following on a 24-hour basis to provide esidents in accordance with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING		05/11/2023		
	PROVIDER OR SUPPLIER E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP 640 THIRD STREET GAYLORD, MN 55334	CODE		
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F 725	this section, license (ii) Other nursing plimited to nurse aid §483.35(a)(2) Exceparagraph (e) of the designate a license nurse on each tour. This REQUIREMED by:  Based on observative review the facility fastaffing to ensure resided in the facility fastaffing to ensure resided in the facility fastaffing include:  R5's quarterly Minit 3/14/23, indicated a required two-persomobility, transfer, of person physical assutilized a wheelchal heart failure, seizur depression, and A R8's quarterly MDS severe cognitive imphysical assist with dressing, toilet use a wheelchair, no rediagnoses included disease that cause and stiffen), Alzheir	ived under paragraph (e) of ed nurses; and ersonnel, including but not es.  ept when waived under is section, the facility must ed nurse to serve as a charge of duty.  NT is not met as evidenced tion, interview, and document esidents received care and led. These deficient practices affect all 33 residents who by.  mum Data Set (MDS) dated severe cognitive impairment, in physical assist with bed ressing, toilet use, and one sist with personal hygiene, ir and diagnoses included: te disorder, anxiety disorder,		F725 s/s E:  Submission of this Respore Correction is not a legal act deficiency exists or that the Deficiency was correctly contour to be construed as an fault by the facility, the Execor any employees, agents individuals who draft or main this Response and Plan In addition, preparation and this Plan of Correction does an admission or agreement the facility of the truth of an or the correctness of any correctness of any correctness of any correctness of any experience of the under state and federal law submission of a Plan of Corten (10) days of the survey to participate in Title 18 and programs. This Plan of Corten (11) This Plan of Corten (12) This Plan of Corten (13) This Plan of Corten (14) This Plan of Corten (15) This Plan of Corten (16) This Plan of Corten (17) This Plan of Corten (18) This Plan of Corten (19) This Plan of Cor	dmission that a is Statement of ited, and is also admission of ecutive Director or other ay be discussed of Correction. In a submission of es not constitute at of any kind by my facts alleged conclusions set as prepared and rection prior to all which may be requirements with at mandate or ection within y as a condition and Title 19		

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG	<b> </b> ` '	E SURVEY PLETED	
		245473	B. WING		<b>I</b>	05/11/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP  640 THIRD STREET  GAYLORD, MN 55334	<u> </u>		
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F 725	lower spine, osteo dementia.  R8's care plan data self-care performa pulmonary fibrosis spinal stenosis of claudication, osteo dementia; intervent grooming, bathing one); shower/bath Saturday PM NAR  R13's quarterly MI intact cognition, reassist with bed mouse, and personal and diagnoses incosteoarthritis of the R13's care plan data alteration in ADL sof bladder (bladder in and weakness extensive A1 (assiteeth; set up and a before bed; freque bladder r/t diuretic malignant neoplas upon arising, mid at hs (bedtime), chrounds.  R17's quarterly MI intact cognition, reassist with bed more assist with assist with a more assistance.	and nerves get compressed in the arthritis of hips, depression, and on 4/7/23, indicated an ADL ance deficit r/t (related to), Alzheimer's disease, anxiety, lumbar region with neurogenic parthritis of hips, depression, ations included dressing, eating, extensive A1 (assist of Wednesday AM hospice, (nursing assistant),  OS dated 4/25/20/23, indicated quired two-person physical ability, transfer, dressing, toilet hygiene, utilized a wheelchair luded: heart failure and eright hip.  Ated 1/30/23, indicated tatus r/t (related to) neoplasm r cancer), CHF, Afib, arthritis in dressing, grooming, bathing st of one), resident has own assist with oral cares in AM and antly incontinent of bowel and use, alteration in mobility and m to bladder, toilet on demand, am/pm, before/after meals and neck/change on NOC (night)  OS dated 4/28/23, indicated quired one-person physical ability, transfer, dressing, toilet hygiene, utilized a wheelchair	F 7	submitted as the facility's of allegation of compliance.  -The process for satisfying requirement has been revirevised as needed to ensureceive care and assistance.  -All residents in the facility potential to be affected if this not met.  -The schedule is reviewed or designee, Scheduler, and Administrator or designee, staffing levels continue to be pursuant to Minnesota Administrator or designee, staffing is tracked and audutilizing direct care per pat (HPPD) via the payroll soft compared against local, st standards; as found on the Home Compare website at Healthcare Management in Payroll Based Journal (PB continue to demonstrate pand future compliance.  -Those educated, using Me Healthcare Management for policy", included but was not administrator, DON, and Sellow and staff.	this ewed and are residents be as needed.  have the his requirement  daily by DON hd/or to ensure be appropriate ministrative g Personnel. dited daily ient day ratios tware and is late, and federal e CMS Nursing hd Monarch htranet. CMS J) reports will ast, present,  onarch Open shift staff of limited to, Scheduler.  cies, the facility ent and		

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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	<u> </u>		
BAYSIDE MANOR LLC			640 THIRD STREET GAYLORD, MN 55334			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
ischemic attack (strofalling, and glaucom the eyeball, causing R17's care plan data self-care performancincluded dressing, g A1 (assist of one), s around 6:30 a.m.  R12's face sheet pridiagnose included: of (conditions that impabrain) with dysarthria paralysis or weakne mouth) and hemiple (paralysis), type 2 dineuropathy (nerve dineuropathy (nerve dineuropathy (nerve dineuropathy extensive assist of of hygiene, toileting an off unit did not occur R137's entry MDS diadmitted on 5/4/23.  On 5/8/23 at 9:48 a. wheelchair, and inditake up to an hour of R13 indicated conce attention during her	dersonal history of transient obke like attack), history of a (increased pressure within gradual loss of sight).  Ded 5/3/23, indicated and ADL ce deficit; interventions frooming, bathing extensive shower/bath Monday am  Inted on 5/11/23, indicated cerebrovascular disease act the blood vessels in the a (speech disorder cause by ss of the muscles of the gia and hemiparesis abetes mellitus with lamage) and weakness.  Description of care and one for dressing, personal distansfers. Walking on and result of the second o	F 7	-In an effort to fill all vacan will continue to contract wit Staffing agencies, as defin Supplemental Nursing Ser (SNSA), and Monarch Hea Management float pool for staffing needs.  -In an effort to fill all vacan will continue to offer "bonumonetary incentives to pot with additional shifts being current staff.  -Staffing will be monitored adequate staffing is achieved and revised as not the current needs of the fare-Audits include, but are not resident and staff interviewed monitoring call light resport the electronic call light systems per week for two (2) weeks times per week for 4 week four (4) weeks; and month one (1) month. Audit result reviewed at QAPI, with any practice corrected at the timoccurrence.  -Director of Nursing or desiresponsible party.	th External ed by the MN vices Agency althcare temporary  cies, the facility ses" or entially assist picked up by  daily to ensure yed to meet the ent will be eeded to reflect cility.  It limited to, both ys, and use time(s) via tem.  ive (5) times s; three (3) s; weekly for ly thereafter for lts will be y deficient me of		

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F 725	with morning cares shortage of staff.  On 5/8/23 at 10:26 wheelchair through room. NA-C stated and ADLs were just staff. NA-C further until now as R5 was confirmed R5 had row, and further vein bed due to shortation of the facility was shortated in the facility was shortated or proving and indicated prefer at 6:00 a.m.  On 5/8/23 at 11:29 not offered or proving and indicated prefer at 6:00 a.m.  On 5/8/23 at 1:39 proving an	a.m., NA-C assisted R5 in the the hallway to the dining R5 was going to breakfast, the completed due to shortage of stated R5 was not assisted as a two person assist. NA-C not requested to sleep until perified other residents were still age of staff.  a.m., R137 stated staff were ght response and had waited staff assistance. R137 stated at staff since her admission on a.m., R137 indicated staff had ded morning assist until now arred to rise and eat breakfast assistance. R137 stated at times, or more for the call lights to be stered the room, turned the call not assist with what she are garding staffing of wait times for call lights to be saft, R13, R2, and R17 all	F 725	-Corrective action will be complet before 6/30/23.	ed on or	
	grievances in the particular will ever change" at	R11 stated she had filed ast but quit because "nothing nd "no one ever listens". R11 ave enough staff and run with 2				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	, , , , , , , , , , , , , , , , , , , ,
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F 725	on 5/8/23 at 2:31 paide (NA)-A stated nursing assistant (Na) she arrived at 12:00 5/7/23, the facility of indicated all the result and dressed for the indicated there are assistance and support attended to untifus room around 12:30 called for assistance help so she did the Review of Resident response forms inconstaffing and call light years of the form director of nurmonitoring call light education with staff 10/22: Residents for the beanswered for DON included reminates before their from director of nurmonitoring call light education with staff 10/22: Residents for the beanswered for DON included reminates are too long the form DON included communicating when toilet to more quick 2/27/23: When toilet too long to come based on the based of the paid too long to come based on the paid to the paid too long to come based on the paid to th	ch has gotten worse over the c.m., during an interview nurse the facility was short one NA) today on the day shift, until 0 p.m. NA-A added yesterday only had 2 NA's also. NA-A idents except R15 were up to day when she arrived. NA-A 4 residents who require servision with eating who were I she arrived in the dining p.m. NA-A indicated she to best she could. (See F550).  Council Meeting minutes luded below concerns with the tresponse times: times feel too long. State when the ey feel that it will be a least 30 or light is answered. Response sing (DON) included we are attimes and working on		5		

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	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP C 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	* · · · · 2 · 2 · ·
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F 725		ents, ask if they want to sit a wait because the resident just	F 7	'25		
	On 5/10/23 at 10:19 she would be responded to the factor of staff and very facility during with the shortage of staff has missed or delayed, extended wait times delayed. NA-D state shift waited until 10 stated the facility has required two assist and caused extended due to the staff shortage.	a.m., NA-D stated at times, onsible for 14-15 residents. cility was short staffed when into were on the day or erified she had worked at the wo NA's. NA-D stated the id caused residents bath delay in call lights answered, s, and residents breakfast ed 4-5 residents on a normal :00 a.m. for breakfast. NA-D ad many residents who with machines for transfers ed wait times for resident's rtage. NA-D indicated cerns about long call light				
	confirmed residents and staff shortage of forwarded the conce (DON). SS-A indication and confirmed the times and would british.	2 a.m., social services (SS)-A brought extended call light concerns to her. She erns to the director of nursing ted call light reports were runfacility had extended call lighting the concerns to morning and alerted the director of				
	(TMA)-A stated the meet resident need shift. TMA-A stated scheduled, she ass medication pass. T	a.m., trained medication aide facility was fully staffed to s with three NA's on the day when two NA's were isted with resident care and MA-A stated when only 2 NA's lents may miss baths or have				

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F 725	required for resident completed timely. Fresidents who required and caused extendinurse would turn the resident needs were confirmed on 5/8/23 timely with breakfast verified residents with morning cares was consistiently morning cares was consistiently morning staffing shortage facility required staffing shortage facility required staff resident cares were nursing staff and recare needed such a lights answered time.  On 5/10/23 at 1:26 schedule was short not have three NA's NA's, the residents answered, and bath the week or delayed the average time for the dining room for On 5/10/23 at 02:06 NA's on the day shi and 1-2 times per with LPN-C stated when resident baths were different day. Nursing the sident day. Nursing the complete states when resident day.	imes.  B a.m., NA-C stated NA's were at morning cares to be further, the facility had many ired two assists with transfers ed wait times. NA-C stated the e call light off, however, e not assisted. NA-C as tor morning cares, and ere in bed until 12:00 p.m. esidents were not assisted until 10:00 a.m. NA-C stated andated for the next shift due. NA-C stated residents in the fassist to and from dining, e rushed due to the shortage of sidents did not receive the as bathing, walking, and call ely.  p.m., NA-A stated the staffed when the facility did son the day shift and with two had a delay in call lights as might get shifted throughout d. NA-A stated 10:00 a.m. was r the last resident assisted to		25		

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		245473	B. WING		0.5	C 5/11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	71172020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 725	director of nursing hired a staffing per administrator was a schedules. The state administrator were star system was strincluded a star place so if someone called mandated to stay from and the evening per was mandated to stay from a seed on casemix higher level of care DON stated expectives within 15 to 20 they were working recently educated sexpectations. The shift with 2 NA's on often. When it hap done until later in the completed. The DO taking admissions choose only low active and admissions choose only low active and she started weeks ago and on was left alone on the building. TMA-since but there show evening shifts. The with only 2 NA's for On 5/11/23 at 9:22 system was implementation.	in 5/10/23 at 3:08 p.m., the (DON) stated they recently son but until then the completing the staffing affing employee and not available for interview. The arted on February 15th which ced by a staff person's name ed in, that person was or the first part of the next shift erson with a star by their name come in early. Staffing was and when residents had a staffing was adjusted up. The tations for answering call lights of minutes. The DON added on call light times currently and staff on call light answering DON stated they do not run a day or evening shift very spened, baths might not be the afternoon but they were still DN stated the facility was but was very particular and suity residents to admit to the state of the facility about 5 or 6 her 4th day at the facility she are floor with no other NA's in a stated that hasn't happened and the had been multiple times		725		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245473	B. WING _			C 11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 725	shift. The DON conthe star system was utilized. She verified short staffed due to implemented or state their scheduled should residents care with call light times were The DON confirme for the day shift. The	e in early for their scheduled offirmed the implementation of its inconsistent and not always and some days the facility was to the star system not aff not being able to stay past iff. The DON indicated in baths, dining delay, extended the aconcern with staff shortage. It wo NA's was not adequate the DON confirmed with two evening shift the needs of the ot always be met. The DON to on 5/8/23, no nurse was and the DON indicated she in the nurse shortage. The DON and call lights answered within the DON indicated she was not issed baths due to the staff.  7 a.m., NA-B stated her shift and at 6:30 a.m. however, was used past her scheduled shift as how. NA-B stated R15's are not provided yet and would assisted with morning cares and at already. NA-B stated the ed call light times, residents all light times, or the evers was not given due staffing.  Siment dated 9/1/2022, daily census of 28-33 affing levels were determined as and resident acuity levels. Wed daily by the scheduler, trator to ensure the staffing sident centered care needs.		25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
245473		B. WING		C 05/11/2023		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	leadership, 1-2 in A direct care; 1-2 in A Nurse's aides; 2-3 i Trained medication and 0 on nights.  Review of the facility February 15, 2023 is an average census schedules identified shifts, but 2 schedules lacked retained the following: February 16th through 16th 2/16/23 - 1 shift, 2/28/23 - 5 hours of March 2023: 3/2/23 - 2 shifts, 3/7/23 - 1 shift, 3/9/23 - 1 shift,	ng included registered nurse M; Licensed nurses providing M, 1-2 PM, and 1 nights. In AM, 2-3 PM, and 1-2 nights. In assistant; 0-1 AM, 0-1 PM  by's staffing schedules for through May 2023, revealed of 33-34 residents. The H 3 NA's on day and evening alled for night shifts. The equired nursing assistants for 1981 1981 1981 1981 1981 1981 1981 198		25		

F 725  Continued From page 56  4/23/23 - 1 shift  4/24/23 - 3 hours.  May 2023:  5/3/23 - 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,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 725  Continued From page 56  4/23/23 - 1 shift 4/24/23 - 3 hours.  May 2023: 5/3/23 - 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,			245473	B. WING			
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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,					640 THIRD STREET	1	
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,	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
21 minutes, 18 minutes, 25 minutes, 32 minutes, 21 minutes, 18 minutes, 24 minutes, 24 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, 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, 21 minutes, 18 minutes. 3/9/23-5/9/23  R13's longest wait times were 17 minutes, 19 minutes, 20 minutes, 28 minutes, 22 minutes, 26 minutes, 23 minutes, 20 minutes, 27 minutes, 32 minutes, 28 minutes, 29 minutes, 27 minutes, 43 minutes, 48 minutes, 36 minutes, 27 minutes, 23 minutes, 48 minutes, 39 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 29 minutes, 28 minutes, 20 minutes, 20 minutes, 21 minutes, 22 minutes, 35 minutes, 28 minutes, 29 minutes, 29 minutes, 41 minutes, 30 minutes, 29 minutes, 41 minutes, 30 minutes, 29 minutes, 41 minutes, 30 minutes, 42 minutes, 28 minutes, 29 minutes, 28 minutes, 20 minutes, 17 minutes, 15 minutes.	F 725	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, pl Facility call light renumerous occasion wait times. The follong wait times, 15 minutes, 18 minutes, 18 minutes, 18 minutes, 18 minutes, 36 minutes, 36 minutes, 36 minutes, 36 minutes, 36 minutes, 36 minutes, 37 minutes, 38 minutes, 39 minutes, 39 minutes, 48 minutes, 48 minutes, 48 minutes, 48 minutes, 48 minutes, 48 minutes, 49 minutes,	us 3 hours.  sponse logs revealed ns of longer than 15 minutes lowing were examples of the rese included but were not ving:  times included: 15 minutes, nutes, 25 minutes, 32 minutes, nutes, 26 minutes, 54 minutes, nutes, 26 minutes, 20 minutes, nutes, 38 minutes, 27 minutes, nutes, 42 minutes, 21 minutes, nutes, 41 minutes, 16 minutes, minutes.  mes were 34 minutes, 18 es, 33 minutes, 21 minutes, 10 minutes, 30 minutes, 18 es, 33 minutes, 21 minutes, 19 es, 38 minutes, 21 minutes, 19 es, 38 minutes, 21 minutes, 23 es, 29 minutes, 27 minutes, 32 es, 29 minutes, 27 minutes, 43 es, 36 minutes, 37 minutes, 23 es, 34 minutes, 29 minutes, 41 es, 28 minutes, 39 minutes, 55 mes were 19 minutes, 28	F 7	25		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  IG	COMPLETED		
		245473	B. WING _		05/11/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
(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 SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	minutes, 46 minute minutes, 36 minute hours and minute. 5/5/23-5/8/23: R137's longest wa 43 minutes, 36 minute hour and 45 minutes, 36 min	times were 17 minutes, 22 es, 40 minutes, 3 hours 40 es, 32 minutes, 22 minutes, 25 es, 22 minutes, 39 minutes, 2 it times included: 19 minutes, nutes, 33 minutes, 52 minutes, utes, 50 minutes.  colicy and procedure, undated, les sufficient numbers of staff competency necessary to rervices for all residents in esident care plans and the t. and certified nursing assistants ours a day to provide direct ces. In the skill requirements of the determined by the needs of the one each resident's plan of the relative to our facility's directed to the administrator or the disprocedure Open Shift Staffing the directure of the procedure of the skift of the administrator or the procedure of the skift of the procedure of the skift of the administrator or the procedure of the skift of the skift of the administrator or the procedure of the skift of the skift of the administrator or the procedure of the skift of the skift of the skift of the administrator or the procedure of the skift of the ski	F 72	25		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER:  A. BUILDING			C (X3) DATE SURVEY		
		245473	B. WING _			11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	occurring after the licensed nursing or shall be filled by revacancies on a volution is not found, the following and open shift vacancy have been designated in the shours of the open s	time the schedule is posted or schedule is posted in the nursing assistant department questing employees to fill such untary basis. If a replacement llowing open shift staffing tilized shall designate by an * the ch shift who will be expected to after all efforts to fill a nexhausted. Employees hift immediately preceding and shift will be expected to cover 4 shift. However, if open shifts d after a designated uch employee will not be oth shifts.  "Store/Prepare/Serve-Sanitary 1)(2)  fety requirements.  cure food from sources lered satisfactory by federal, orities.  e food items obtained directly rs, subject to applicable State	F 81			6/30/23

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		. ,	(X3) DATE SURVEY COMPLETED	
		245473			05/11/2023		
NAME OF I	PROVIDER OR SUPPLIER	<u>                                     </u>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	•	11/2020	
DAVCIDE				640 THIRD STREET			
BAYSIDE	E MANOR LLC			GAYLORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 812	Continued From p		F 81	12			
		Service safety. ENT is not met as evidenced					
		ation, interview and document		F812 s/s F			
	review, the facility failed to ensure dishwashing sanitization was appropriately monitored and			Cubmission of this Deepen	oo and Dlan of		
	•	orage of food brought in for, or		Submission of this Respon Correction is not a legal ad			
by residents, was safe for consumption. This had				deficiency exists or that this			
	the potential to effe	ect all residents in the facility.		Deficiency was correctly cit	,		
	Findings include:			not to be construed as an a fault by the facility, the Exe			
	UNLABELED AND	UNDATED FOOD		or any employees, agents or individuals who draft or ma			
	0 5/0/00 1 0 15			in this Response and Plan	of Correction.		
		a.m., a refrigerator in a din the dining room accessible		In addition, preparation and this Plan of Correction does			
		y and visitors who brought food		an admission or agreemen			
	,	facility was inspected. Food		the facility of the truth of an	,		
		served in this refrigerator		or the correctness of any c	onclusions set		
	included the follow	ng: age for coffee, opened, undated		forth in the allegations.			
	and labeled expire	• •		Accordingly, the Facility ha	s prepared and		
	•	e opened and undated, 3/4		submitted this Plan of Corr	• •		
	empty with expirat			the resolution of any appea	,		
		that contained corn on the cob		filed solely because of the	•		
	· •	veled, undated and unlabeled. that contained a shrimp salad,		under state and federal law submission of a Plan of Co			
	undated and unlab	•		ten (10) days of the survey			
		dding dessert on a cookie sheet		to participate in Title 18 and			
	3/4 empty covered	with tin foil unlabeled and		programs. This Plan of Co			
	undated.			submitted as the facility's c	redible		
		g bottles undated and		allegation of compliance.			
	-	ety. No expiration present.  erages unopened were present.		-The process for satisfying	this		
	aidpio otiloi bovi	s. ages anoponed word procent.		requirement has been revie			
	During interview of	n 5/9/23 at 11:01 a.m., cook		revised as needed, to ensu			
		refrigerator was for residents		sanitization is appropriately			
		ere to date and label the food		food brought in for, or by restored and labeled appropr			
	LINEV DIN ID IDAFA (	was insure wan monitored	1	- I Sidied and laneled anninni	IAIHIV		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245473		l` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245473	B. WING		C 05/11/2023	
	PROVIDER OR SUPPLIER		(	STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	O BE COMPLETION	
F 812	expired foods listed kitchenette refrigerator in the discarded including containers. C-B conwere stored in their residents foods. C-should be labeled with All facility products opened. If unlabled discarded.  A facility policy and into a Monarch Head dated 4/97 included -Purpose is to provinutritious, healthy felf a resident's family their loved one, and sanitary manner in accept this and modulated the sanitary manner in accept the sanitary manner in accept this and modulated the sanitary manner in accept the sanitar	a.m., opened, undated and labove remained in the lator.  3 at 9:35 a.m., C-B stated the ining room was cleaned out the labeled or dated were labeled or dated were labeled or dated were labeled with late or undated, should be latthcare Management Facility distinct the latthcare Management Facility distinct the latthcare Management food for distinct food can be stored in a latthcare management food for distinct food can be stored in a latthcare management food for distinct food can be stored in a latthcare management food for distinct food can be stored in a latthcare management food for distinct food can be stored in a latthcare management food for distinct food can be stored in a latthcare management food for distinct food food for distinct food for distinct food food food food food food food foo	F 812	<ul> <li>All residents residing in the facility the potential to be affected if this requirement is not met.</li> <li>The policy and procedures necessance these requirements were revand revised as needed to ensure the appropriately labeled and staff are of the equipment being used and luse it.</li> <li>Education for necessary Bayside staff has been initiated utilizing Model Healthcare Management policy and procedures.</li> <li>Audits will be completed three (3 per week for two (2) weeks; two (2 per week for one (1) week; and model thereafter for one (1) month. Auding will be reviewed at QAPI, with any deficient practice corrected at the occurrence.</li> <li>Culinary Director or designee is responsible party.</li> <li>Corrective action will be complete before 6/30/23.</li> </ul>	ssary to riewed food is aware now to  Manor onarch d  I times (1) times (2) times (3) time onthly t results (4) time of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245473	B. WING			C /11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 640 THIRD STREET GAYLORD, MN 55334	· · · · · · · · · · · · · · · · · · ·	11/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 812	opposite wall that in Temperature Log (I column for wash te Fahrenheit (F) and million) 50-100. C-0 temperature of the documented results had a hard time see Next to the clip boar Chlorine Strips. C-0 they were for and the them on dishwasher C-C then went into PH (a figure express a solution) strips and dishwasher PH white reading). C-C attenturned a blue color. During interview on indicated the rinse on the Dishmachine rinse temperature, attempted testing depth paper white (not shown the chlorine been using them.  Interview on 5/9/23 he was not aware of dishwasher needed Dishmachine Temperature on the Dishmachine Temperature of the was 150-160 degree water was 180 degree water	ge 61 strips. A clip board hung on the cluded a Dishmachine Low temperature). It included a imperature 120-140 degrees Chlorine PPM (parts per content of the wash and rinse cycles and so on that form. C-C added she eing the temperature gauge. In the strip remained white. It is another room and brought out it is ing the acidity or alkalinity of a dattempted to check in turned the strip white (no indicting 50 PPM of chlorine.  5/9/23 at 10:50 a.m., C-A is indicated in the chemical strips and the transcription of the chemical strips and the transcription. The chemical strips and the transcription of the chemical strips and the transcription of the chemical strips and the transcription. The chemical strips and the transcription of the		12		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			TE SURVEY MPLETED	
		245473	B. WING		05	C /11/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 812	proper policy and p	ge 62 3 at 9:35 a.m., C-B stated the rocedure for dishwasher low ical sanitization) was located.	F 8	12		
F 836 SS=D	A policy and proced revised October 20 - High temperature 150-165 degrees F rinse temperature 1 secondsLow temperature c sanitization) wash t and final rinse with seconds.	dishwasher wash temperature for at least 45 seconds with 65-180 degrees for a least 12 dishwasher (chemical emperature 120 degrees F 50 PPM chlorine for a least 10 Fed/State/Locl Law/Prof Std	F 8	36		6/30/23
	§483.70(b) Compliance Local Laws and Proceed Laws and Proceed Italiance with all local laws, regulation accepted profession that apply to professuch a facility.  §483.70(c) Relation Regulations. In addition to comp	ensed under applicable State and ofessional Standards. Derate and provide services in applicable Federal, State, and ons, and codes, and with anal standards and principles sionals providing services in				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245473	B. WING		05/11/2023		
	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP 640 THIRD STREET GAYLORD, MN 55334	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 836	regulations, include pertaining to nondiscrimination CFR part 84); nonage (45 CFR part basis of race, cold disability (45 CFR subjects of resear and abuse (42 CF individually identific CFR parts 160 and provisions may renon-compliance with This REQUIREMED by:  Based on interviet facility failed to be supplemental nurs requirements; the services from Mid an SNSA, which with the supplemental supplemental findings include:  Review of staff sc 5/11/23, verified St registered nurse second and interviet administrator control of the supplemental staff of the supple	visions of other HHS ling but not limited to those liscrimination on the basis of lional origin (45 CFR part 80); on the basis of disability (45 lidiscrimination on the basis of 91); nondiscrimination on the or, national origin, sex, age, or part 92); protection of human ch (45 CFR part 46); and fraud fR part 455) and protection of lable health information (45 d 164). Violations of such other sult in a finding of with this paragraph. ENT is not met as evidenced  we and document review, the in compliance with the sing service agency (SNSA) facility obtained nursing west Clinical Resources (MCR), was not was registered with the required per MN State Statute § on 1. This had the potential to ents who received services from staff.  hedules dated 5/5/23 through hifty Key provided supplemental staffing to the facility.  w on 5/8/23 at 12:22 p.m., the firmed Shifty Key did not finnesota Department of	F 8	F836 s/s D  Submission of this Respor Correction is not a legal addeficiency exists or that the Deficiency was correctly content to be construed as an fault by the facility, the Execor any employees, agents individuals who draft or main this Response and Plan In addition, preparation and this Plan of Correction does an admission or agreement the facility of the truth of an or the correctness of any of forth in the allegations.  Accordingly, the Facility has submitted this Plan of Corthe resolution of any appendiced solely because of the	dmission that a is Statement of ited, and is also admission of ecutive Director or other ay be discussed of Correction. It is not constitute at of any kind by any facts alleged conclusions set as prepared and rection prior to all which may be		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245473	B. WING			)5/11/2023	
	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZII 640 THIRD STREET GAYLORD, MN 55334	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO T  DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 836	Continued From particles A policy on agency	ge 64 staffing was not received.	F 8	under state and federal la submission of a Plan of C ten (10) days of the surve to participate in Title 18 a programs. This Plan of C submitted as the facility's allegation of compliance.  -The process for satisfyin requirement has been revised as needed, to ensupplemental nursing ser (SNSA) is on the approve to use.  - All residents residing in the potential to be affecte requirement is not met.  - The facility process has and revised as needed to agencies are on the SNS a contract and periodicall ensure compliance.  - The facility Administrato Nursing have been traine requirement.  - Audits will be completed (4) weeks, and monthly the (2) months.  - Audit results will be review the any deficient practice time of occurrence.  - Administrator or designed party.	correction withing as a condition and Title 19 correction is credible  g this viewed and sure any vice agency and SNSA list prior to signify reviewed to the facility have a corrected at the facility	or e I I I I I I I I I I I I I I I I I I	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245473	B. WING		C 05/11/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/11/2020
BAYSIDE	MANOR LLC			640 THIRD STREET GAYLORD, MN 55334	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE COMPLÉTION
F 836	Continued From pa	ge 65	F 830		ad on or
				- Corrective action will be complet before 6/30/23.	ed on or

F5473034

PRINTED: 07/27/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245473	B. WING _		05/	/10/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUNDERSE ACT	JLD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	-S	K 0	00			
	conducted by the M Public Safety, State 05/10/2023. At the Manor, LLC was for requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) 101, Life Sa Existing Health Car NFPA 99, Health Car NFPA 99, Health Car THE FACILITY'S PO ALLEGATION OF CO DEPARTMENT'S A SIGNATURE AT THE PAGE OF THE CMS USED AS VERIFICA	at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 e and the 2012 edition of are Facilities Code.  OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.  F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE					
	REGULATIONS HAACCORDANCE WI PLEASE RETURN CORRECTION FOR DEFICIENCIES (K-	R THE FIRE SAFETY					
ABORATORY	PAPER COPY OF TIS NOT REQUIRED	THE PLAN OF CORRECTION	IATURE	TITLE		(X6) DATE	

06/19/2023

**Electronically Signed** 

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.

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´´	TIPLE CONSTRUCTION  NG 01 - MAIN BUILDING 01	l \ /	TE SURVEY MPLETED
		245473	B. WING		05	/10/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUSE FOLLOWING INFO.  1. A detailed described taken or planned to a surface to ensure the sustained.  2. Address the mapping the remedy.  3. Indicate how the future performance sustained.  4. Identify who is actions and monito.  5. The actual or puther remedy.  Bayside Manor LLC one-story in height, fire sprinkler protect of Type II(000) consin height, has no based on the sustained.	pections Division Suite 145 3-5145, OR  @state.mn.us  RRECTION FOR EACH OT INCLUDE ALL OF THE DRMATION:  cription of the corrective action of correct the deficiency.  easures that will be put in deficiency does not reoccur.  the facility plans to monitor to ensure solutions are  responsible for the corrective ring of compliance.  croposed date for completion of  C was constructed in 1974, is has a full basement, is fully sted and was determined to be struction. In 2008, is one-story asement, is fully fire sprinkler determined to be of Type	KO			
	detection in the cor	re alarm system with smoke ridors and spaces open to the monitored for automatic fire				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> `´	LE CONSTRUCTION  01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245473	B. WING		05/1	0/2023
	PROVIDER OR SUPPLIER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 40 THIRD STREET SAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	census of 33 at the The requirement at	apacity of 42 beds and had a time of the survey.  42 CFR, Subpart 483.70(a) is	K 000			
K 711 SS=C	patients and for the an emergency. Employees are perinformed with their copy of the plan is a operator or with second provides for all components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 through 18 19.7.2.2, 19.7.2.3	location Plan location Plan lan for the protection of all ir evacuation in the event of odically instructed and kept duties under the plan, and a readily available with telephone curity. The plan addresses the uired of staff per 18/19.7.2.1.2 of the fire safety plan	K 711			6/30/23
	Based on a review and staff interview, complete Fire Eme (2012 edition), Life (3). This deficient fi widespread impact facility.  Findings include:  On 05/10/2023 at 1	of available documentation the facility failed to maintain a rgency Plan per NFPA 101 Safety Code, section 19.7.2.2 nding could have a on the residents within the		Submission of this Response and F Correction is not a legal admission deficiency exists or that this Statem Deficiency was correctly cited, and not to be construed as an admissio fault by the facility, the Executive Di or any employees, agents or other individuals who draft or may be discontinuous.	that a nent of is also n of irector	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245473	B. WING _		05/10/2023
	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
K 711	Emergency Plan did staff shall immediate emergency within the An interview with M	d not contain the verbiage of ely call 911 to report a fire	K 7	in this Response and Plan of Cor In addition, preparation and subm this Plan of Correction does not can admission or agreement of an the facility of the truth of any facts or the correctness of any conclus forth in the allegations.  Accordingly, the Facility has prep submitted this Plan of Correction the resolution of any appeal which filed solely because of the require under state and federal law that in submission of a Plan of Correction ten (10) days of the survey as a contract to participate in Title 18 and Title programs. This Plan of Correction submitted as the facility's credible allegation of compliance.  -The process for satisfying this requirement has been reviewed a revised as needed to ensure that Emergency Plan did not contain the verbiage of staff shall immediately to report a fire emergency within the facility.  -All occupants of the facility have potential to be affected if this requirement.  -The Fire Emergency Plan verbia been updated and reflects the state immediately call 911 to report a fire emergency within the facility.  -The Maintenance Director or designed and the facility.	ission of onstitute y kind by alleged ons set ared and prior to may be ments nandate n within ondition 19 n is on the Fire ne y call 911 he the hirement ge has ff shall re
				responsible party.	

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG 01 - MAIN BUILDING 01	` ′	E SURVEY IPLETED
		245473	B. WING _		05/	10/2023
	PROVIDER OR SUPPLIER  E MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 711	Continued From pa	ge 4	K 7	11		
				-Corrective action will be completed before 6/30/23.	ted on or	
	Electrical Systems CFR(s): NFPA 101	- Essential Electric Syste	K 9 <sup>2</sup>	18		6/30/23
	Maintenance and To The generator or or and associated equipment of the service within 10 secriterion is not metrocess shall be process and with NFPA 110.  Generator sets are under load 30 minured and conditions in the set of all EES in competent personnestored energy power accordance with NFC circuit breakers are program for periodic components is established to the process of the pro	ther alternate power source sipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this esafety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 exercised once every 36 uous hours. Scheduled test in include a complete and automatic or manual loads, and are conducted by sel. Maintenance and testing of er sources (Type 3 EES) are in EPA 111. Main and feeder inspected annually, and a				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´	LE CONSTRUCTION  O1 - MAIN BUILDING 01	` '	(X3) DATE SURVEY COMPLETED	
		245473	B. WING		05/1	0/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE	
K 918	111, 700.10 (NFPA This REQUIREMENT by: Based on a review and staff interview, reliable power transgenerator per NFP Care Facilities Cod 6.4.3.1 and NFPA 14.1(b). This deficie widespread impact facility.  Findings include: On 05/10/2023 at 1 during the monthly conducted on 02/03 seconds to transfer emergency power at emergency general 03/23/2023 it was retransfer power from An interview with Management of the power from the	NFPA 99), NFPA 110, NFPA	K 918	K918 s/s C  Submission of this Response and Correction is not a legal admissio deficiency exists or that this State Deficiency was correctly cited, and not to be construed as an admiss fault by the facility, the Executive or any employees, agents or othe individuals who draft or may be did in this Response and Plan of Correction In addition, preparation and submit this Plan of Correction does not contain admission or agreement of any the facility of the truth of any facts or the correctness of any conclusified forth in the allegations.  Accordingly, the Facility has preparation and submitted this Plan of Correction the resolution of any appeal which filed solely because of the require under state and federal law that may be submission of a Plan of Correction ten (10) days of the survey as a contained to participate in Title 18 and Title programs. This Plan of Correction submitted as the facility's credible allegation of compliance.  -An area for improvement was idea when, upon document review, the no evidence to support the facility maintained a reliable power transferency generator.	n that a ment of d is also ion of Director rection. ission of onstitute y kind by alleged ons set ared and prior to may be ments andate n within ondition 19 in is		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G <b>01 - MAIN BUILDING 01</b>	(X3) DATE SURVEY COMPLETED
		245473	B. WING _		05/10/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K 918	Continued From pa	ge 6	K 91	8	
				-This has the potential to affect all residents if this requirement is not r	net.
				-Maintenance Supervisor has been reeducated to the requirement and identified area of concern will be co immediately.	the
				<ul> <li>Audits will be completed weekly for (2) weeks; bi-weekly for four (4) we and monthly thereafter for one (1) not any deficient practice will be identification of occurrence.</li> </ul>	eks; nonth. ed and
				-Audit results will be reviewed at QA Areas of concern will be corrected immediately.	∖PI.
				-Maintenance Director or designee responsible party.	is
14.000			14.00	-Corrective action will be completed	
K 926 SS=F	CFR(s): NFPA 101	ualifications and Training	K 92	6	6/30/23
	Personnel Personnel concerne maintenance and ha cylinders are trained provide continuing e guidelines and usag serviced only by per maintenance and o 11.5.2.1 (NFPA 99)	ualifications and Training of ed with the application, andling of medical gases and d on the risk. Facilities education, including safety ge requirements. Equipment is rsonnel trained in the peration of equipment.  IT is not met as evidenced			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	<b>l</b> `´´	LE CONSTRUCTION  6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245473	B. WING		05/1	0/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 926	and staff interview, staff training concernaintenance and hocylinders NFPA 99 Facilities Code, see finding could have residents within the Findings include:  On 05/10/2023 at 1 review of available documents could never been trained with maintenance and hocylinders.  An interview with Market staff training could never be a seen trained with the could never be a seen t	of available documentation the facility failed to conduct erned with the application, andling of medical gases and (2012 edition), Health Care ction 11.5.2.1. This deficient a widespread impact on the facility.  0:30 AM, it was revealed by a documentation, training of be located to show that staff with the application, andling of medical gases and laintenance Director and Manager verified this deficient	K 926	Submission of this Response and Correction is not a legal admission deficiency exists or that this State Deficiency was correctly cited, and not to be construed as an admission fault by the facility, the Executive or any employees, agents or othe individuals who draft or may be don'this Response and Plan of Corlin addition, preparation and submithis Plan of Correction does not can admission or agreement of any the facility of the truth of any facts or the correctness of any conclust forth in the allegations.  Accordingly, the Facility has preparation and submitted this Plan of Correction the resolution of any appeal which filed solely because of the require under state and federal law that is submission of a Plan of Correction to participate in Title 18 and Title programs. This Plan of Corrections ubmitted as the facility's credible allegation of compliance.  -The process for satisfying this requirement has been reviewed a revised as needed to ensure all in Bayside Manor nursing staff are the application, maintenance, and handling of medical gases and contains the summand of the survey as a contain the summand of the survey as a contain the summand that is a summand the summand that is a summand the summand that is a	ement of a sion of Director iscussed rection. In a sion of constitute by kind by a lleged sions set on within condition 19 on is ements and a secessary trained in direct of the constitute of the condition on the condition on the condition t		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING <b>01 - MAIN</b>		E CONSTRUCTION  01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED				
		245473	B. WING			05/	0/2023
	ROVIDER OR SUPPLIER		•	64	TREET ADDRESS, CITY, STATE, ZIP CODE  40 THIRD STREET  6AYLORD, MN 55334	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 926	Continued From pa	ge 8	K 9	26	-All occupants of the facility have the potential to be affected if this required is not met.  -Necessary Bayside Manor staff with educated on the application, maintand handling of medical gases and cylinders. Education will be provided a new course / module in Healthca Academy. This course is required thire, and annually thereafter.  -The Human Resource Director will ensure appropriate staff are complicated with online education upon hire and annually thereafter.  - Audits will be completed weekly for (4) weeks, and monthly thereafter for (2) months.  -The Human Resource Director or designee is responsible party.  -Corrective action will be completed before 6/30/23.	l be enance d using re upon for two	



#### 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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.

Bayside Manor LLC June 13, 2023 Page 2

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00040	B. WING		C	
	00619	D. WING		05/11/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BAYSIDE MANOR LLC	640 THIR	D STREET			
DATOIDE MANOR LLC	GAYLOR	D, MN 55334			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
2 000 Initial Comments		2 000			
****ATTE	ENTION*****				
NH LICENSING	CORRECTION ORDER				
144A.10, this correspond to a survey found that the deficient herein are not corrected shall with a schedule of the Minnesota Deputermination of we corrected requires requirements of the number and MN R When a rule contact comply with any of lack of compliance re-inspection with	Minnesota Statute, section ection order has been issued ey. If, upon reinspection, it is ciency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of partment of Health.  The ther a violation has been compliance with all e rule provided at the tag ule number indicated below, ins several items, failure to the items will be considered any item of multi-part rule will sment of a fine even if the item				
	uring the initial inspection was				
that may result from orders provided the Department with	hearing on any assessments m non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.				
conducted at your Minnesota Departr facility was NOT in Licensure and the issued. Please ind	TS: a licensing survey was facility by surveyors from the nent of Health (MDH). Your compliance with the MN State following correction orders are icate in your electronic plan of e reviewed these orders and				

Minnesota Department of Health

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

(X6) DATE

TITLE

**Electronically Signed** 

06/19/23

Minnesota Department of Health

AND BLAN OF CORRECTION TO THE IDENTIFICATION NUMBERS		A. BUILDING:		COMPLETED		
		00619	B. WING		C 05/11/2023	3
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			STREET	,,,,		
BAYSIDE	BAYSIDE MANOR LLC GAYLOF					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPL	LETE
2 000	Continued From pa	ge 1 en they will be completed.	2 000			
	The following composition deficiency issued. H54732088C (MN0 H54732090C (MN0 H54732108C (MN0 H54739135C (MN0 H54739921C (MN0 H54732026C (MN0 with a licensing order.)	laints were reviewed with no  0087517) 0086351) 0084339) 0088066) 0091604) 0092249)  laints were reviewed. 0093129 and MN00093241) er issued at 0265 0090107) with a licensing				
	H54732089C (MN0 order issued at 083 H54732102C (MN0 order issued at 026 H54732106C (MN0 order issued at 083 H54732107C (MN0 order issued at 083 order issued at 083	0086778) with a licensing 0, 0900, and 0920. 0093219) with a licensing 0090098) with a licensing 0090102) with a licensing 0087632) with a licensing				
	the State Licensing Federal software. To assigned to Minnes Nursing Homes. The appears in the far-letted in the "Summ column and replace the correction order the findings which a statute after the statute after the statute."	correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number off column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of the state in violation of the state tement, "This Rule is not met ollowing the surveyor's				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00619	B. WING		1	C 11/2023	
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/		
			D STREET	TATE, ZII OODE			
BAYSIDE	E MANOR LLC	GAYLORE	), MN 55334				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	findings are the Suggested Method of Correction and Time Period for Correction.						
	receipt of State lices the Minnesota Department of Heal you electronically. Is necessary for State enter the word "CO available for text. You electronic State lices heading completion be corrected prior to the Minnesota Department is enrolled in ePOC	participate in the electronic insure orders consistent with artment of Health in 14-01, available at state.mn.us/facilities/regulatiog1.html The State licensing ed on the attached Minnesota th orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the insure process, under the date, the date your orders will be electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of					
	FOURTH COLUMN "PROVIDER'S PLA	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.					
2 010	MN Rule 4658.0020 GENERAL; Require	Subp 1 LICENSING IN ed	2 010			6/30/23	
	chapter, a state lice where nursing home	red. For the purpose of this ense is required for a facility e care is provided for five or persons who are not acutely					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
						;
		00619	B. WING		05/1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSID	E MANOR LLC	640 THIRE GAYLORE	D STREET D, MN 55334			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 010	Continued From page	ge 3	2 010			
	by: Based on interview facility failed to be in supplemental nursin requirements; the faservices from Midw an SNSA, which was commissioner as ready 144A.71 Subdivision affect all 33 residenthe supplemental strandings include:  Review of staff schees 5/11/23, verified Shift registered nurse state During an interview administrator confirmed register with the Mir Health's (MDH) SNSA policy on agency subject to the supplemental state of the supplemental state	edules dated 5/5/23 through fty Key provided supplemental affing to the facility.  on 5/8/23 at 12:22 p.m., the med Shifty Key did not nesota Department of SA registry.  staffing was not received.  HOD OF CORRECTION: The signee could develop, review, es and procedures regarding SNSA's. The administrator or cate all appropriate staff on cedures. The administrator or elop monitoring systems to		Corrected		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00619	B. WING		O5/11/	/2023
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE	1 00/11/	72020
BAYSIDE	MANOR LLC		D STREET			
			D, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 010	Continued From pa	ge 4	2 010			
	(21) days.					
2 265	MN Rule 4658.0085 Resident Health Sta	Notification of Chg in atus	2 265		6	6/30/23
	policies to guide star physicians, physicians physicians practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notificate.  A. an accident is results in injury and physician intervention.  B. a significant physician intervention.  B. a significant physical, mental, or example, a deterior psychosocial status conditions or clinicate.  C. a need to alterample, a need to	involving the resident which has the potential for requiring on; change in the resident's respectively for ation in health, mental, or in either life-threatening all complications; ter treatment significantly, for discontinue an existing form adverse consequences, or to				
	D. a decision t resident from the nu	o transfer or discharge the ursing home; or				
	E. expected an	d unexpected resident deaths.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
		00619	B. WING		05/1	) 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, \$	STATE, ZIP CODE		
BAYSIDI	E MANOR LLC		D STREET D, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 5	2 265			
	by: Based on interview facility failed to provavilable clinical information physical change for	and document review, the vide the physician with all ormation for a significant 1 of 1 residents (R136) who otification of change.		Corrected.		
	Findings include:					
	admission on 3/4/23 surgical aftercare for system, discitis (infe	rinted on 5/10/23, indicated and included diagnoses of surgery on the nervous ection of intervertebral disc muscle in the back) abscess, ic kidney disease.				
	assessment dated a cognitively intact, ha hearing, clear speed understood. R136 r	Alinimum Data Set (MDS) 3/10/23, indicated: R136 was ad adequate vision and ch, could understand and be equired extensive assistance mobility, transfers, and not walk.				
	would be free from infection). The care symptoms of UTI for care plan indicated in cognition related Spanish speaking be	ated 3/4/23 indicated R136 symptoms of UTI (urinary tract plan did not identify potential or staff to monitor. Further, the R136 was at risk for alteration to diagnoses. R136 was out knew some English and on maker. Staff were to in orientation.				
	(treats infections), 2 daily for psoas abso	e, generic name for Rocephin, 2 gm (grams) intravenously				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00619	B. WING		05/1	) 1/2023
	PROVIDER OR SUPPLIER	640 THIRE		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	blood sugar levels).  3/4/23 - Blood sugar bedtime four times mellitus).  3/27/23 - Obtain uri related to burning was provider.  3/30/23 - UTI progradays.  3/30/23 - Levofloxas one tablet daily for the communications incommunications incommunic	y for hyperglycemia (high rs before/after meals and a day for DM (diabetes ne sample for UA (urinalysis) with urination. Fax results to ess note every shift for 14 cin (treats infections) 500 mg, UTI for 14 days. w, the following fax dicated: a.m., a Fax indicated the last d a hard time starting flow of e bladder. Only small amount ttempt using the urinal. ng progress notes, this fax I provider (MP)-I the following p.m.). The same day ), a fax was received from	2 265			

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED		
		00619	B. WING		05/1	) 1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE	MANOR LLC	640 THIRE GAYLORE	O STREET O, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 7	2 265			
	·	teria. A urine culture (UC)				
	Progress notes indisequence of events in which they inform of R136's painful ur possible urinary retecompletely emptying nursing staff did not changes in R136's documented in progress notes did nursing assessment together all available provider.  Furthermore, there R136 reported pain resulted. Nursing prollowing four-day tith 1) 3/26/23 at 5:51 aurination and voided 2) 3/27/23 at 1:41 progression from the provider.  Supplying the provider of	cated, nurses documented a from 3/26/23 through 3/30/23 ned providers MP-I and MP-J ination, bladder pain and ention (difficulty urinating and g bladder) via fax. However, a communicate other physical condition that had been gress notes, including nausea, n, and hallucinations. not indicate a comprehensive thad been conducted to pull e information and report it to a was delay from the first time ful urine to the final UA being rogress notes indicated the meline:  .m., R136 experienced painfuld a small amount.  .m., R136 experienced and urgency. Message left a.m., fax to MP-I regarding on.  .m., order received from MP-J  .m., clinic was contacted for method to obtain the UA; clean th (catheterization - inserting a a.m., 19 hours after the order				
	catheterized specin	nen was received. The ined and delivered to the lab				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00619	B. WING		05/1	) 1/2023
NIAME OF I				TATE 710 000E	1 00/1	1/2020
NAME OF I	PROVIDER OR SUPPLIER	640 THIRE	,	TATE, ZIP CODE		
BAYSIDE	E MANOR LLC		, MN 55334			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 265	Continued From pa	ge 8	2 265			
	7) 3/29/23 at 1:27 prinformed the facility not been ordered when Another UA would redo a UC. 8) 3/29/23 at 11:20 obtained. 9) 3/30/23 at 8:18 and delivered to the clin 10) 3/30/23 at 12:24 faxed to MP-I and an antibiotic.  On 3/31/23 from ap 3:30 a.m., R136's continuation of the clin and an antibiotic.	.m., a call from the lab a UC was needed as one had ith the initial UA order. need be obtained in order to p.m., a second UA was .m., the urine specimen was ic lab. I p.m., the UA results were in order was received for an proximately 12:00 midnight to ondition began to deteriorate.				
	R136 experienced a mg/dL (milligram per abdominal pain, low elevated pulse of 10 increased respirator minute. During this contact with the DO department (ED) at a.m., R136 was tranat 11:33 a.m., the factor at the nearby howas septic and in Dodiabetes complication excess blood acids triggered by infection a larger hospital. Or facility was informed R136 had passed a	a drop in blood sugar to 30 or deciliter), developed 10/10 or blood pressure of 92/36, 26 beats per minute, and ry rate of 36 breaths per time, the nursing staff was in N and the emergency a nearby hospital. At 3:30 of serred to the ED. On 3/31/23 of serred to the ED. On 3/31/23 of series informing them R136 KA (diabetic ketoacidosis - a con where the body produces or ketones and can be n) and would be transferred to a 3/31/23 at 7:30 p.m., the diby the larger hospital that				
	timeline above from reviewed with region and the director of racknowledged the total	3/26/23 to 3/30/23 was nal nurse consultant (RNC)-H nursing (DON). RNC-H imeline was accurate. RNC-H was a potential delay in				

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, ,	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00619	B. WING		05/1	) 1/2023
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC	640 THIRE	,	TATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ET BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
delay was partially attrib only a UA on 3/27/23 and DON who was new to he timeframe, was aware Fithe hospital on 3/31/23. Not been aware of the confusion and hallucinate addition to UTI symptom of 3/26/23 to 3/30/23.  During the same interviews tated they would have a 3/26/23 to 3/30/23 to hapicture of all symptoms back pain, confusion, and addition to UTI symptom comprehensive nursing the assessment, contact information.  On 5/11/23 at 11:38 a.m. telephone message with MP-I, including purpose date of birth, and reques nurse stated she would Intent of phone call was 3/26/23 to 3/30/23 and may 3/31/23.  During an interview on 5 licensed practical nurse day shift the week of 3/2 involved in the direct calinvolved with fax and phase and a series of the series of th	C-H stated part of the s being cautious and order the preferred urine specimen - clean urther, RNC-H stated the puted to MP-J ordering and not also a UC. The er role during this R136 was transferred to However, the DON had linical changes of tions R136 experienced in ans during the time frame  ew, RNC-H and the DON expected nurses from eve looked at the bigger R136 was experiencing and hallucinations, in ans, and perform a assessment. Following a provider with the expected a call back. Triage forward message to MP-I. It to discuss timeline from a rapid deterioration on a control of R136, but was	2 265			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
00619	B. WING			C I <b>1/2023</b>	
BAYSIDE MANOR LLC	DDRESS, CITY, ST RD STREET RD, MN 55334	TATE, ZIP CODE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	ULD BE	(X5) COMPLETE DATE	
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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00619	B. WING			C <b>11/2023</b>
NAME OF PROVIDER OR SUPPLIER BAYSIDE MANOR LLC	640 THIRI	DRESS, CITY, S D STREET D, MN 55334	TATE, ZIP CODE		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
in obtaining and read to the clinic. From the 1:43 p.m., when the requesting a UA, the at 10:37 a.m., with catheter to use, at those 20 hours, must the facility not answer clinic on 3/27/23 at obtain a straight called back the new the size urinary capractice for a nurse policy and/or text be material. In addition organize their thou contacting the profession of the prof	unters further identified a delay sulting the initial UA. A total of k place between the facility and e first phone call on 3/27/23 at e facility called the clinic of the last phone call on 3/28/23 the order for the size urinary total of 20 hours elapsed. Of ore than 17 hours were from wering a phone call from the tat. 4:57 p.m., with the order to eath urine specimen. The clinic ext morning with that order.  Atheter was within the scope of the to determine using facility ook or online clinical reference on, nursing staff failed to eights and questions when wider to request a UA for R136 a clean catch or straight cath at size urinary catheter to use). It is delay was in addition to the enthe lab requested a second	2 265			
Condition or Status would promptly no provider of change condition. The nur attending physicia had been a signific physical/emotiona notifying the physic nurse would make	Change in a Resident's s, undated, indicated the facility tify the physician/health is in the residents medical se would notify the residents n or physician on-all when there cant change in the residents /mental condition. Prior to cian or healthcare provider, the detailed observations and				
provider. Except in	d pertinent information for the medical emergencies, be made within 24 hours of				

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AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:					SURVEY PLETED	
			D WING			С
		00619	B. WING		05/2	11/2023
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
BAYSIDE	MANOR LLC	640 THIRE GAYLORE	), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	condition or status. resident physical or comprehensive ass condition would be SUGGESTED MET director of nursing (ensure policies and notification of reside physician were accessful (DON) or designee staff on the policies timely notification of The director of nursidevelop monitoring compliance.	the residents medical/mental If a significant change in the mental condition occurred, a essment of the residents	2 265			
2 800	MN Rule 4658.0510 Staffing requirement Subpart 1. Staffing home must have or number of qualified registered nurses, linursing assistants to residents at all nursing all buildings if more involved. This included and vacation replace.  This MN Requirement.	requirements. A nursing duty at all times a sufficient nursing personnel, including scensed practical nurses, and o meet the needs of the es' stations, on all floors, and are than one building is des relief duty, weekends,	2 800			6/30/23
		on, interview, and document iled to provide sufficient		Corrected.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00619	B. WING		C 05/11/2	2022
		00019			05/11/2	2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BAYSIDE	E MANOR LLC		D STREET D, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE C	(X5) COMPLETE DATE
2 800	Continued From page	ge 13	2 800			
	assistance as need	esidents received care and ed. These deficient practices affect all 33 residents who				
	Findings include:					
	3/14/23, indicated s required two-person mobility, transfer, draw person physical assutilized a wheelchai heart failure, seizure depression, and Alza R8's quarterly MDS severe cognitive imphysical assist with dressing, toilet use, a wheelchair, no rej diagnoses included disease that causes and stiffen), Alzhein stenosis of lumbar in claudication (spinal	num Data Set (MDS) dated evere cognitive impairment, in physical assist with bed ressing, toilet use, and one sist with personal hygiene, ir and diagnoses included: e disorder, anxiety disorder, izheimer's disease.  dated 4/18/20/23, indicated pairment, required one-person bed mobility, transfer, and personal hygiene, utilized ected care behaviors and is pulmonary fibrosis (lung is lung tissue to scar, thicken, ner's disease, anxiety, spinal region with neurogenic nerves get compressed in the rthritis of hips, depression,				
	self-care performant pulmonary fibrosis, spinal stenosis of lu- claudication, osteoa dementia; interventing, grooming, bathing, one); shower/bath V Saturday PM NAR (	d on 4/7/23, indicated an ADL ce deficit r/t (related to) Alzheimer's disease, anxiety, ambar region with neurogenic arthritis of hips, depression, ons included dressing, eating, extensive A1 (assist of Vednesday AM hospice, (nursing assistant),  S dated 4/25/20/23, indicated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		• • • • • • • • • • • • • • • • • • • •	(X3) DATE SURVEY COMPLETED	
	00619	B. WING			C <b>11/2023</b>	
NAME OF PROVIDER OR SUPPLIER BAYSIDE MANOR LLC	640 THIR	DDRESS, CITY, ST RD STREET RD, MN 55334	TATE, ZIP CODE			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
assist with bed mouse, and personal and diagnoses incosteoarthritis of the R13's care plan da alteration in ADL sof bladder (bladder) in and weakness extensive A1 (assisteeth; set up and a before bed; freque bladder r/t diuretic malignant neoplas upon arising, mid at hs (bedtime), clarounds.  R17's quarterly Mintact cognition, reassist with bed mouse, and personal and walker and dispolyosteoarthritis, ischemic attack (sfalling, and glaucothe eyeball, causing A1 (assist of one) around 6:30 a.m.  R12's face sheet plagnose included (conditions that imbrain) with dysarther and mouse, and personal and walker and dispolyosteoarthritis, ischemic attack (sfalling, and glaucothe eyeball, causing A1 (assist of one) around 6:30 a.m.	quired two-person physical obility, transfer, dressing, toilet hygiene, utilized a wheelchair luded: heart failure and e right hip.  ated 1/30/23, indicated tatus r/t (related to) neoplasm r cancer), CHF, Afib, arthritis in dressing, grooming, bathing st of one), resident has own assist with oral cares in AM and ently incontinent of bowel and use, alteration in mobility and m to bladder, toilet on demand, am/pm, before/after meals and neck/change on NOC (night)  OS dated 4/28/23, indicated quired one-person physical obility, transfer, dressing, toilet hygiene, utilized a wheelchair					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						С	
		00619	B. WING		05/1	1/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BAYSIDE	MANOR LLC	640 THIRI GAYLORI	O STREET D, MN 55334				
(V 4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	<u>,                                      </u>	PROVIDER'S PLAN OF CORRECTI	ON	(Y5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 15	2 800				
	(paralýsis), type 2 d	egia and hemiparesis iabetes mellitus with damage) and weakness.					
	3/22/23, indicated notes behaviors including extensive assist of	ange MDS assessment dated noderate cognitive deficit, no rejection of care and one for dressing, personal d transfers. Walking on and r.					
	R137's entry MDS dated 5/4/23, indicated admitted on 5/4/23.						
	wheelchair, and ind take up to an hour of R13 indicated concattention during her	m., R13 was seated in a icated staff assistance would or more during the mornings. erns were brought to facility's care conference, and further e or twice a week call lights answered.					
	and NA-C indicated	a.m., R5 was observed in bed staff had not provided R5 or breakfast due to the					
	wheelchair through room. NA-C stated and ADLs were just staff. NA-C further staff. NA-C further staff now as R5 was confirmed R5 had not be staff.	a.m., NA-C assisted R5 in the the hallway to the dining R5 was going to breakfast, completed due to shortage of stated R5 was not assisted a two person assist. NA-C not requested to sleep until rified other residents were still age of staff.					
	untimely with call lig	a.m., R137 stated staff were tht response and had waited staff assistance. R137 stated					

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AND PLAN OF CORRECTION INTERPRETATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00619	B. WING		05/11	/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE	E MANOR LLC	640 THIRI				
		GAYLORE	), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 16	2 800			
	the facility was short 5/4/23.	t staff since her admission on				
	not offered or provid	a.m., R137 indicated staff had ded morning assist until now rred to rise and eat breakfast				
	waited for an hour of answered. Staff ent	m., R8 stated, at times, or more for the call lights to be ered the room, turned the call not assist with what she				
	p.m., R11 voiced co the facility and long answered. R20, R3 voiced agreement. grievances in the pa will ever change" ar added they don't ha	Incil meeting on 5/9/23 at 1:30 oncerns regarding staffing of wait times for call lights to be 33, R7, R13, R2, and R17 all R11 stated she had filed ast but quit because "nothing and "no one ever listens". R11 ove enough staff and run with 2 och has gotten worse over the				
	aide (NA)-A stated to nursing assistant (Nashe arrived at 12:00 5/7/23, the facility of indicated all the rest and dressed for the indicated there are assistance and sup not attended to unti- room around 12:30 called for assistance help so she did the	.m., during an interview nurse the facility was short one IA) today on the day shift, until p.m. NA-A added yesterday nly had 2 NA's also. NA-A idents except R15 were up day when she arrived. NA-A 4 residents who require ervision with eating who were I she arrived in the dining p.m. NA-A indicated she e but no one else arrived to best she could. (See F550).				
	Review of Resident	Council Meeting minutes				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00619	B. WING		05/1	) 1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
		640 THIRE	, ,	717 (12, 211 0052		
BAYSIDE	E MANOR LLC		, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
PRÉFIX TAG	Continued From paresponse forms included staffing and call light 9/22: call light wait to they call for help the minutes before their from director of nurmonitoring call light education with staff 10/22: Residents fee to be answered for DON included remin when toileted to che 11/17/22: Resident light waits are too lot toilet way too long we from DON included communicating when toilet to more quickle 2/27/23: When toilet to more quickle 2/27/23: When toilet too long to come be indicated education when toileting reside bit or if they should needs a short time.  On 5/10/23 at 10:19 she would be responsed a short time.  On 5/10/23 at 10:19 she would be responsed to the fact two nursing assistant evening shift and vertacility during with the shortage of staff has missed or delayed, extended wait times.	ge 17  uded below concerns with it response times: imes feel too long. State when by feel that it will be a least 30 r light is answered. Response sing (DON) included we are times and working on	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		COMPLETE
	stated the facility had required two assist and caused extended	100 a.m. for breakfast. NA-D and many residents who with machines for transfers and wait times for resident's rtage. NA-D indicated				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>I</b> ` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
	00619	B. WING			C <b>11/2023</b>
NAME OF PROVIDER OR SUPI	640 THI	ADDRESS, CITY, S RD STREET RD, MN 55334			
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC)	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
On 5/10/23 at confirmed resi and staff short forwarded the (DON). SS-A i and confirmed times and wou stand up meet nursing.  On 5/10/23 at (TMA)-A state meet resident shift. TMA-A s scheduled, sh medication pa were working, extended call  On 5/10/23 at required for recompleted tim residents who and caused ex nurse would tu resident needs confirmed on stimely with breverified reside NA-C stated of with morning of was consistier to staffing sho facility required resident cares	e concerns about long call light  11:22 a.m., social services (SS)-A idents brought extended call light tage concerns to her. She concerns to the director of nursing ndicated call light reports were run I the facility had extended call light ald bring the concerns to morning ting and alerted the director of  11:37 a.m., trained medication aid d the facility was fully staffed to needs with three NA's on the day tated when two NA's were e assisted with resident care and ss. TMA-A stated when only 2 NA' residents may miss baths or have	e see			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		, 20.22	· ·· · · · · · · · · · · · · · · · · ·			
	00619	B. WING				
NAME OF PROVIDER OR SUPP	LIER STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-		
		D STREET	- · · · · -, - · · · · · · · · · · · · ·			
BAYSIDE MANOR LLC		D, MN 55334	<b>,</b>			
(X4) ID SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX (EACH DEFIC	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETE DATE	
2 800 Continued From	n page 19	2 800				
lights answere	d timely.					
On 5/10/23 at schedule was a not have three NA's, the resid answered, and the week or de the average tin the dining room.  On 5/10/23 at NA's on the da and 1-2 times LPN-C stated or resident baths different day. No lights and asked During intervied director of nurshired a staffing administrator or schedules. The administrator or star system was included a star so if someone mandated to stand the evening was mandated based on case higher level of DON stated exwas within 15 to they were work.	:26 p.m., NA-A stated the short staffed when the facility did NA's on the day shift and with two ents had a delay in call lights baths might get shifted throughout layed. NA-A stated 10:00 a.m. was ne for the last resident assisted to					
expectations.	he DON stated they do not run a					
	s on day or evening shift very happened, baths might not be					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00619	B. WING		05/1	) 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDI	E MANOR LLC	640 THIRE GAYLORE	O STREET O, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	completed. The DO taking admissions is choose only low act facility.  During interview on stated she started a weeks ago and on I was left alone on the building. TMA-E since but there show evening shifts. The with only 2 NA's for On 5/11/23 at 9:22 system was implemented or stay late or come shift. The DON conthe star system was utilized. She verified short staffed due to implemented or stated their scheduled shift residents care with call light times were their scheduled shift residents would not stated the day shift. The NA's on the day or residents would not stated the day shift nurse scheduled an worked to cover the stated she expected 10-15 minutes. The aware residents mis shortage.	e afternoon but they were still on stated the facility was but was very particular and uity residents to admit to the 5/10/23 at 5:25 p.m., TMA-B at the facility about 5 or 6 ner 4th day at the facility she is e floor with no other NA's in a stated that hasn't happened uld be three NA's on day and re had been multiple times	2 800			

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	С	
00619 B. WING 05/11/20	05/11/2023	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE		
BAYSIDE MANOR LLC  GAYLORD, MN 55334		
	(X5) COMPLETE DATE	
2 800 Continued From page 21  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 - 1 shift, 3/9/23 - 1 shift, 3/10/23 - 1 shift, 3/		

Minnesota Department of Health

AND PLAN OF CORRECTION INTERPRETATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	B. WING		C 05/11/2023
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC	640 THIR	DDRESS, CITY, STANDERSS, CITY, STANDERSS	TATE, ZIP CODE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
numerous occasion wait times. The following wait times. The limited to the following 3/1/23 - 5/8//23:  R12's longest wait to 29 minutes, 15 minutes, 18 minutes, 18 minutes, 18 minutes, 24 minutes, 24 minutes, 36 minutes, 36 minutes, 34 minutes, 36 minutes, 37 minutes,	ponse logs revealed so of longer than 15 minutes owing were examples of the ese included but were not ing: imes included: 15 minutes, nutes, 25 minutes, 32 minutes, utes, 24 minutes, 25 minutes, 24 minutes, 25 minutes, 27 minutes, utes, 38 minutes, 27 minutes, utes, 42 minutes, 21 minutes, utes, 42 minutes, 16 minutes, utes, 21 minutes,	2 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00619	B. WING		C 05/11/2023	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE MANOR LLC	640 THIRE GAYLORD	) STREET ), MN 55334			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES JUST BE PRECEDED BY FULL JUENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE	
hour 26 minutes, 30 minutes. 3/9/23-5/9/23 R13's longest wait time minutes, 20 minutes, 31 minutes, 31 minutes, 48 minutes, 48 minutes, minutes, 42 minutes, minutes, 42 minutes, minutes, 45 minutes, 49/23-5/8/23: R5's longest wait time minutes, 20 minutes, 416/23-5/9/23: R17's longest wait time minutes, 46 minutes, 36 minutes, 36 minutes, 27 minutes, 27 minutes, 36 minutes, 27 minutes, 36 minutes, 37 minutes, 37 minutes, 38 minutes, 39 minutes, 39 minutes, 39 minutes, 30 minutes, 31 minutes, 32 minutes, 36 minutes, 36 minutes, 37 minutes, 37 minutes, 37 minutes, 38 minutes, 39 minutes, 39 minutes, 39 minutes, 30 minutes, 3	33 minutes, 21 minutes, 1 minutes, 30 minutes, 18  nes were 17 minutes, 19 38 minutes, 21 minutes, 23 22 minutes, 26 minutes, 32 29 minutes, 27 minutes, 43 36 minutes, 37 minutes, 23 , 34 minutes, 29 minutes, 41 28 minutes, 39 minutes, 55  nes were 19 minutes, 28 17 minutes, 15 minutes.  nes were 17 minutes, 22 40 minutes, 3 hours 40 32 minutes, 22 minutes, 25 22 minutes, 39 minutes, 2  mes included: 19 minutes, 25 22 minutes, 39 minutes, 2  mes included: 19 minutes, 25 29 minutes, 30 minutes,	2 800			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00619	B. WING		05/11	I/ <b>202</b> 3
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE	E MANOR LLC	640 THIRE				
			), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 24	2 800			
	·	ns relative to our facility's irected to the administrator or				
	Policy dated 2/22/16 -In order to ensure for all residents, it is maintain staffing lever government mandar are open shifts for a nursing or nursing or nursing a will make every efformation occurring after the solicensed nursing or shall be filled by reduced a vacancies on a volution of the following procedure will be uterposted schedules and individual(s) on each	the safety and quality of care the policy to consistently yels that are at or above the tes. Therefore when there any reason on the licensed assistant schedule, the facility of to fill the open shifts time the schedule is posted or schedule is posted in the nursing assistant department questing employees to fill such intary basis. If a replacement owing open shift staffing ilized shall designate by an * the h shift who will be expected to				
	vacancy have been designated in the shadoling an open shours of the open soccur both prior and	ch employee will not be				
	administrator, DON adequate policy and sufficient staffing bar population to staffing received safe, adequate with toileting, bathin ulcer care, medicati	HOD OF CORRECTION: The or designee should ensure programs are developed for ased on the resident gavailability so residents uate and timely assistance on administration, meals, and the facility should educate				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
00619		B. WING			C <b>05/11/2023</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE	BAYSIDE MANOR LLC GAYLO					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPED T	D BE	(X5) COMPLETE DATE
2 800	resident care to enscare and services we facility should report to the quality assurations to the quality assurations to the quality assurations to the facility and the facility should report to the quality assurations to the quality assurations to the facility should report to the quality assurations to the facility should report to the quality assurations to the facility should report to the quality assurations.	es and perform audits of sure residents are receiving with adequate staffing. The the findings of these audits ance performance  I) committee for further o determine compliance or the	2 800			
2 830	Subpart 1. Care in receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensity of the comprehensive plan of care as designed as much as written order from the comprehensive of the comprehensive plan of care as designed as much as written order from the comprehensive plan of care as designed as much as provided as provided as much as provided as much as provided as p	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			6/30/23
	by: Based on observation review the facility fac	ent is not met as evidenced on, interview, and document iled to provide sufficient esidents received care and ed. These deficient practices affect all 33 residents who y.		Corrected.		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00619	B. WING		05/1	; 1/2023
NAME OF F	PROVIDER OR SUPPLIER				1 03/1	1/2023
		640 THIRI	,	STATE, ZIP CODE		
BAYSIDE	MANOR LLC		), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 26	2 830			
	Findings include:					
	3/14/23, indicated some required two-person mobility, transfer, draw person physical associated a wheelchair heart failure, seizure depression, and Alam R8's quarterly MDS severe cognitive imphysical assist with dressing, toilet use, a wheelchair, no rejudiagnoses included disease that causes and stiffen), Alzhein stenosis of lumbar in claudication (spinal)	num Data Set (MDS) dated evere cognitive impairment, in physical assist with bed ressing, toilet use, and one sist with personal hygiene, ir and diagnoses included: e disorder, anxiety disorder, izheimer's disease.  dated 4/18/20/23, indicated pairment, required one-person bed mobility, transfer, and personal hygiene, utilized ected care behaviors and is pulmonary fibrosis (lung is lung tissue to scar, thicken, ner's disease, anxiety, spinal region with neurogenic nerves get compressed in the rthritis of hips, depression,				
	self-care performant pulmonary fibrosis, spinal stenosis of lu- claudication, osteoa dementia; interventing grooming, bathing,	d on 4/7/23, indicated an ADL ce deficit r/t (related to) Alzheimer's disease, anxiety, ambar region with neurogenic arthritis of hips, depression, ions included dressing, eating, extensive A1 (assist of Vednesday AM hospice, (nursing assistant),				
	intact cognition, req assist with bed mob use, and personal h	S dated 4/25/20/23, indicated uired two-person physical ility, transfer, dressing, toilet ygiene, utilized a wheelchair ided: heart failure and				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00619	B. WING		05/1	; 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
BAYSIDI	E MANOR LLC	640 THIRE	O STREET O, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	alteration in ADL starof bladder (bladder hip and weakness of extensive A1 (assisteeth; set up and assisteeth; set up and and art his (bedtime), che rounds.  R17's quarterly MDS intact cognition, requassist with bed mobuse, and personal hand walker and diagonal polyosteoarthritis, pischemic attack (stralling, and glaucom the eyeball, causing R17's care plan dat self-care performant included dressing, and around 6:30 a.m.  R12's face sheet prediagnose included: (conditions that important brain) with dysarthriparalysis or weakner mouth) and hemiple (paralysis), type 2 diagnose; type 2 dia	right hip.  ed 1/30/23, indicated atus r/t (related to) neoplasm cancer), CHF, Afib, arthritis in dressing, grooming, bathing to of one), resident has own exist with oral cares in AM and atly incontinent of bowel and use, alteration in mobility and in to bladder, toilet on demand, m/pm, before/after meals and eck/change on NOC (night)  S dated 4/28/23, indicated uired one-person physical bility, transfer, dressing, toilet bygiene, utilized a wheelchair	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00619	B. WING		1	C 1 <b>1/2023</b>
BAYSIDE MANOR LLC			DRESS, CITY, S  D STREET  D, MN 55334	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	3/22/23, indicated in behaviors including extensive assist of hygiene, toileting ar off unit did not occur. R137's entry MDS of admitted on 5/4/23.  On 5/8/23 at 9:48 at wheelchair, and indicated about once took one hour to be a considered about one took one hour to be and NA-C indicated with morning cares shortage of staff.  On 5/8/23 at 10:26 wheelchair through room. NA-C stated and ADLs were just staff. NA-C further staff. NA-C stated and ADLs were just staff. NA-C further staff	ange MDS assessment dated noderate cognitive deficit, no rejection of care and one for dressing, personal not transfers. Walking on and r.  dated 5/4/23, indicated  .m., R13 was seated in a icated staff assistance would or more during the mornings. erns were brought to facility's care conference, and further se or twice a week call lights answered.  a.m., R5 was observed in bed staff had not provided R5 or breakfast due to the  a.m., NA-C assisted R5 in the the hallway to the dining R5 was going to breakfast, completed due to shortage of stated R5 was not assisted a two person assist. NA-C not requested to sleep until rified other residents were still rified other residents were still	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	1 ` '		E SURVEY PLETED
	00619	B. WING			C <b>11/2023</b>
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC	DDRESS, CITY, STANDERSS, CITY, STANDERSS	TATE, ZIP CODE			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
and indicated preferat 6:00 a.m.  On 5/8/23 at 1:39 p waited for an hour of answered. Staff ent light off, and would needed.  During resident courp.m., R11 voiced courbe facility and long answered. R20, R3 voiced agreement. It grievances in the pawill ever change" are added they don't has staff frequently whice past 3 months.  On 5/8/23 at 2:31 praide (NA)-A stated to nursing assistant (Nahe arrived at 12:00 5/7/23, the facility of indicated all the reseand dressed for the indicated there are assistance and sup not attended to untire room around 12:30 called for assistance help so she did the Review of Resident response forms included the staffing and call light.	ded morning assist until now red to rise and eat breakfast  .m., R8 stated, at times, or more for the call lights to be ered the room, turned the call not assist with what she  ncil meeting on 5/9/23 at 1:30 oncerns regarding staffing of wait times for call lights to be 33, R7, R13, R2, and R17 all R11 stated she had filed ast but quit because "nothing at "no one ever listens". R11 ove enough staff and run with 2 ch has gotten worse over the  .m., during an interview nurse the facility was short one lA) today on the day shift, until 0 p.m. NA-A added yesterday nly had 2 NA's also. NA-A idents except R15 were up day when she arrived. NA-A 4 residents who require ervision with eating who were I she arrived in the dining p.m. NA-A indicated she e but no one else arrived to best she could. (See F550).  Council Meeting minutes luded below concerns with				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC  SUBMANOR STREET ORDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334  SECRET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334  SECRET STATE STATE OF PROVIDER OR SUPPLIER  SERVICE STATE STATE OF PROVIDER OR STATE STATE OF PROVIDERS OR STATE STATE OF PROVIDERS OR STATE STATE OF PROVIDERS OR STATE STATE STATE OF PROVIDERS OR STATE STATE OF PROVIDERS OR STATE STATE STATE OF PROVIDERS OR STATE STATE OF PROVIDERS OR STATE STATE STATE STATE OF PROVIDERS OR STATE STA	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REQUATORY OR LSC IDENTIFYING INFORMATION)   TAG   D PREFIX   REQUATORY OR LSC IDENTIFYING INFORMATION)   TAG   D PREFIX   TAG   TAG   PREFIX   TAG			00619	B. WING			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (TAKE))  2 830 Continued From page 30 rimutes 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 tolleted 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 tolleting, staff leave and take way too long to come back. Response from DON indicated education given to all nursing staff that when tolleting esicients, 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 NAs. NA-D stated the shortage of staff had caused residents beatfast delayed. NA-D stated 4-5 residents to 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	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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On 5/10/23 at 11:22 a.m., social services (SS)-A		minutes before thei from director of nurs monitoring call light education with staff 10/22: Residents fe to be answered for DON included remit when toileted to che 11/17/22: Resident light waits are too lot toilet way too long with from DON included communicating when toilet to more quickle 2/27/23: When toilet too long to come be indicated education when toileting reside bit or if they should needs a short time.  On 5/10/23 at 10:19 she would be responsed or delayed, extended wait times delayed. NA-D stated the facility during with the shortage of staff has missed or delayed, extended wait times delayed. NA-D stated the facility has required two assists and caused extended due to the staff short residents voice contimes.	r light is answered. Response sing (DON) included we are times and working on.  el they wait for their call light a long time. Response from nded to check in on resident eck when they are done. are still stating that the call ong and they are sitting on the vaiting for staff. Response educated staff to be en they have a resident on the y respond to call light. ting, staff leave and take way ack. Response from DON given to all nursing staff that ents, ask if they want to sit a wait because the resident just of a.m., NA-D stated at times, estility was short staffed when not swere on the day or erified she had worked at the wo NA's. NA-D stated the d caused residents bath delay in call lights answered, and residents on a normal coo a.m. for breakfast. NA-D and many residents who with machines for transfers ed wait times for resident's reage. NA-D indicated cerns about long call light				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00619	B. WING		C 05/11/2023
	PROVIDER OR SUPPLIER	640 THIRE	, ,	TATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE
2 830	and staff shortage of forwarded the conc (DON). SS-A indicated and confirmed the fittimes and would bristand up meeting a nursing.  On 5/10/23 at 11:37 (TMA)-A stated the meet resident need shift. TMA-A stated scheduled, she assemedication pass. The were working, resident extended call light to the completed timely. For residents who required for resident caused extended nurse would turn the resident needs were confirmed on 5/8/23 timely with breakfast verified residents who required for residents who required to the resident needs were confirmed on 5/8/23 timely with breakfast verified residents who required the resident cares were nursing staff and recare needed such a lights answered time.  On 5/10/23 at 1:26	s brought extended call light concerns to her. She erns to the director of nursing ted call light reports were run acility had extended call lighting the concerns to morning and alerted the director of  'a.m., trained medication aide facility was fully staffed to swith three NA's on the day when two NA's were isted with resident care and MA-A stated when only 2 NA's ents may miss baths or have imes.  'a.m., NA-C stated NA's were it morning cares to be further, the facility had many ared two assists with transfers ed wait times. NA-C stated the e call light off, however, e not assisted. NA-C and assisted at or morning cares, and ere in bed until 12:00 p.m. esidents were not assisted until 10:00 a.m. NA-C stated andated for the next shift due. NA-C stated residents in the fassist to and from dining, a rushed due to the shortage of sidents did not receive the as bathing, walking, and call	2 830		

Minnesota Department of Health

OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	00619	B. WING		05/1	) 1/2023
ROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE ZIP CODE		
TO VIDER OR OUT LIER		, ,	717(12, 211 °CC)2		
MANOR LLC					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Continued From page	ge 32	2 830			
NA's, the residents answered, and bath the week or delayed the average time for	had a delay in call lights s might get shifted throughout l. NA-A stated 10:00 a.m. was the last resident assisted to				
NA's on the day shift and 1-2 times per want LPN-C stated when resident baths were different day. Nursin	t was considered fully staffed eek 2 NA's were scheduled.  2 NA's were scheduled, missed or pushed to a g staff helped answer call				
director of nursing (hired a staffing personal administrator was consciously schedules. The staff administrator were not star system was star included a star place so if someone called mandated to stay for and the evening personal was mandated to consider level of care DON stated expectations was within 15 to 20 they were working or recently educated star expectations. The Doshift with 2 NA's on often. When it happed done until later in the completed. The DOshift with 2 DOShift wit	DON) stated they recently on but until then the ompleting the staffing fing employee and not available for interview. The rted on February 15th which ed by a staff person's name d in, that person was in the first part of the next shift is son with a star by their name ome in early. Staffing was and when residents had a staffing was adjusted up. The ations for answering call lights minutes. The DON added on call light times currently and taff on call light answering DON stated they do not run a day or evening shift very bened, baths might not be e afternoon but they were still N stated the facility was				
	SUMMARY STA- (EACH DEFICIENCY REGULATORY OR LS)  Continued From page not have three NA's NA's, the residents answered, and bath the week or delayed the average time for the dining room for On 5/10/23 at 02:06 NA's on the day shift and 1-2 times per was LPN-C stated when resident baths were different day. Nursin lights and asked the During interview on director of nursing (hired a staffing persadministrator was conschedules. The staff administrator was conschedules. The staff administrator were not star system was staffing persadministrator were not star system.	ROVIDER OR SUPPLIER STREET ADI  MANOR LLC	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, S  640 THIRD STREET GAYLORD, MN 55334  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 32  10 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 was completing the staffing schedules. The staffing employee and administrator was completing the staffing schedules as the staffing employee and administrator was completing the staffing schedules as the staffing employee and administrator was completing the staffing schedules as the staffing employee and administrator was completing the staffing schedules as the staffing employee and administrator was 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 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 o	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET GAYLORD, MN 55334  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 32  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, resident baths were missed or pushed to a different day. 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The DON stated the facility was taking adminissions but was very particular and	ROVIDER OR SUPPLIER  MANOR LLC  640 THIRD STREET GAYLORD, MN 55334  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 32  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's Astated 10:00 a.m. was the average time for the last resident assisted to the dining room for breakfast.  During interview 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, 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.  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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 aftermoon but they were still completed. The DON stated they know they particular and

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STATE FORM BSGS11 If continuation sheet 33 of 69

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00619	B. WING		05/1	C 1/2023
BAYSIDE MANOR LLC			DRESS, CITY, S D STREET D, MN 55334	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	stated she started a weeks ago and on he was left alone on the the building. TMA-Besince but there show evening shifts. There with only 2 NA's for On 5/11/23 at 9:22 a system was implemented or started to stay late or come shift. The DON contracts their scheduled shift residents care with call light times were the day shift. The DON confirmed for the day shift. The NA's on the day or cresidents would not stated the day shift nurse scheduled and worked to cover the stated she expected 10-15 minutes. The aware residents mis shortage.  On 5/11/23 at 10:37 was supposed to er mandated and stays someone did not shift not show the stays are supposed to er mandated and stays someone did not shift not shif	5/10/23 at 5:25 p.m., TMA-B at the facility about 5 or 6 her 4th day at the facility she e floor with no other NA's in stated that hasn't happened ald be three NA's on day and the had been multiple times	2 830			

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2 830  Continued From page 34  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 neineds 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 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,		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED	
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC  (X4) ID PREFIX TAG  CACH DEFICIENCY MUST BE PRECEDED BY PLLL  TAG  COntinued From page 34  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 9/17/2022, 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, 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 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 15th through 28th: 2/16/23 - 1 shift, 2/28/23 - 5 hours on day shift. March 2023: 3/223 - 2 shifts, 3/723 - 1 shift,			00619				/2023
BAYSIDE MANOR LLC  SUMMARY STATEMENT OF DEFICIENCIES  GAYLORD, MN 55334  C(4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 34  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; 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: 3/7/23 - 1 shift, 3/7/23 - 1 shift,	NAME OF F	PROVIDER OR SLIPPLIER	STREET AD	DRESS CITY S	STATE ZIP CODE		
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March 2023: 3/2/23 - 2 shifts, 3/7/23 - 1 shift,		schedules lacked rethe following: February 16th throu	equired nursing assistants for				
		March 2023: 3/2/23 - 2 shifts,	n day 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,		3/9/23 - 1 shift, 3/10/23 - 1 shift, 3/11/23 - 1 shift, 3/17/23 - 1 shift, 3/20/23 - 1 shift, 3/21/23 - 1 shift,	s 5 hours on other shifts,				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00619	B. WING		05/1	) 1/2023
	PROVIDER OR SUPPLIER	640 THIRI	DRESS, CITY, S D STREET D, MN 55334	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	numerous occasion wait times. The following wait times. The limited to the following 3/1/23 - 5/8//23: R12's longest wait to 29 minutes, 15 minutes, 18 minutes, 18 minutes, 24 minutes, 36 minutes, 36 minutes, 36 minutes, 34 minutes, 34 minutes, 34 minutes, 34 minutes, 34 minutes, 36 minutes, 36 minutes, 3713/23-5/9/23: R8's longest wait times, 32 minutes, 32 minutes, 32 minutes	ponse logs revealed is of longer than 15 minutes owing were examples of the ese included but were not ing: imes included: 15 minutes, autes, 25 minutes, 32 minutes, utes, 24 minutes, 25 minutes, 24 minutes, 25 minutes, 26 minutes, 27 minutes, autes, 38 minutes, 27 minutes, autes, 42 minutes, 21 minutes, autes, 42 minutes, 21 minutes, autes, autes, 21 minutes, autes, autes, 21 minutes, autes,	2 830			

Minnesota Department of Health

PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 36  R13's longest wait times were 17 minutes, 19 minutes, 20 minutes, 28 minutes, 29 minutes, 26 minutes, 32 minutes, 31 minutes, 29 minutes, 27 minutes, 43 minutes, 48 minutes, 36 minutes, 29 minutes, 41 minutes, 42 minutes, 35 minutes, 28 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 28 minutes, 28 minutes, 28 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 28 minutes, 29 minutes, 41 minutes, 28 minutes, 29 minutes, 28 minutes, 28 minutes, 28 minutes, 28 minutes, 29 minutes, 28 minutes, 29 minutes, 28 minutes, 29 minutes, 28 minutes, 29 minutes, 29 minutes, 28 minutes, 29 minutes, 20	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
BAYSIDE MANOR LLC  GAYLORD, MN 55334   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830 Continued From page 36  R13's longest wait times were 17 minutes, 19 minutes, 20 minutes, 28 minutes, 29 minutes, 27 minutes, 23 minutes, 48 minutes, 36 minutes, 29 minutes, 29 minutes, 23 minutes, 48 minutes, 38 minutes, 29 minutes, 41 minutes, 42 minutes, 38 minutes, 29 minutes, 41 minutes, 42 minutes, 38 minutes, 29 minutes, 41 minutes, 48 minutes, 36 minutes, 37 minutes, 23 minutes, 48 minutes, 38 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 39 minutes, 41 minutes, 35 minutes, 28 minutes, 28 minutes, 28 minutes, 29 minutes, 41 minutes, 20 minutes, 41 minutes, 21 minutes, 41 minutes, 42 minutes, 43 minutes, 44 minutes, 21 minutes, 44 minutes, 21 minutes, 41 minutes, 42 minutes, 43 minutes, 44 minutes, 45 minutes, 45 minutes, 47 minutes, 48 minutes, 47 minutes, 48 minutes, 48 minutes, 49 minutes, 40 minutes		00619	B. WING			
(X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 36  R13's longest wait times were 17 minutes, 19 minutes, 20 minutes, 28 minutes, 29 minutes, 27 minutes, 23 minutes, 48 minutes, 29 minutes, 27 minutes, 23 minutes, 48 minutes, 34 minutes, 29 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 28 minutes, 29 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 28 minutes, 29 minutes, 29 minutes, 41 minutes, 35 minutes, 28 minutes, 29 minutes, 28 minutes, 41 minutes, 35 minutes, 28 minutes, 28 minutes, 29 minutes, 41 minutes, 29 minutes, 29 minutes, 29 minutes, 41 minutes, 29 minutes, 29 minutes, 29 minutes, 41 minutes, 29 minutes, 29 minutes, 29 minutes, 21 minutes, 29 minutes, 41 minutes, 29 minutes, 29 minutes, 29 minutes, 41 minutes, 29 minutes, 29 minutes, 29 minutes, 41 minutes, 29 minutes, 29 minutes, 29 minutes, 21 minutes, 29 minutes, 41 minutes, 29 minutes, 29 minutes, 29 minutes, 29 minutes, 21 minutes, 29 minutes, 21 minutes, 21 minutes, 21 minutes, 22 minutes, 23 minutes, 24 minutes, 25 minutes, 26 minutes, 27 minutes, 28 minutes, 29 minutes, 29 minutes, 29 minutes, 20 minu	NAME OF PROVIDER OR SUPPLIER	PLIER STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830 Continued From page 36  R13's longest wait times were 17 minutes, 19 minutes, 20 minutes, 38 minutes, 21 minutes, 23 minutes, 28 minutes, 29 minutes, 27 minutes, 43 minutes, 48 minutes, 36 minutes, 27 minutes, 41 minutes, 42 minutes, 38 minutes, 29 minutes, 39 minutes, 41 minutes, 35 minutes, 28 minutes, 29 minutes, 39 minutes, 41 minutes, 35 minutes, 28 minutes, 29 minutes, 39 minutes, 41 minutes, 35 minutes, 28 minutes, 29 minutes, 28 minutes, 29 minutes, 28 minutes, 29 minutes, 28 minutes, 20 minutes, 17 minutes, 28 minutes, 20 minutes, 21 minutes, 22 minutes, 23 minutes, 24 minutes, 25 minutes, 28 minutes, 29 minutes, 20 minutes, 2	BAYSIDE MANOR LLC					
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	PREFIX (EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES SIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
minutes, 36 minutes, 32 minutes, 25 minutes, 25 minutes, 27 minutes, 27 minutes, 28 minutes, 29 minutes, 21 minutes, 25/5/23-5/8/23:  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.	R13's longest wait minutes, 20 minute minutes, 28 minute minutes, 48 minute minutes, 42 minute minutes, 42 minute minutes, 35 minute minutes, 35 minute minutes, 20 minute 4/16/23-5/9/23: R5's longest wait to minutes, 20 minute 4/16/23-5/9/23: R17's longest wait minutes, 36 minute minutes, 36 minute minutes, 27 minute hours and minute. 5/5/23-5/8/23: R137's longest wait minutes, 36 minute minute	wait times were 17 minutes, 19 inutes, 38 minutes, 21 minutes, 23 inutes, 22 minutes, 26 minutes, 32 inutes, 29 minutes, 27 minutes, 43 inutes, 36 minutes, 37 minutes, 23 inutes, 36 minutes, 37 minutes, 23 inutes, 38 minutes, 29 minutes, 41 inutes, 28 minutes, 39 minutes, 55 minutes, 28 minutes, 17 minutes, 15 minutes, 20 minutes, 40 minutes, 3 hours 40 inutes, 32 minutes, 22 minutes, 25 inutes, 22 minutes, 29 minutes, 20 minutes, 30 minutes, 20 minutes, 30 minutes, 20 minutes, 30 minutes, 30 minutes, 30 minutes, 30 minutes, 50	2 830			

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
	00619	B. WING		C 05/11/2023	
NAME OF PROVIDER OR SUPPLIE	R STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE MANOR LLC	640 THIRE	STREET			
		), MN 55334			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD SHO	D BE COMPLETE	
2 830 Continued From	page 37	2 830			
Facility's policy are Policy dated 2/22 -In order to ensur for all residents, it maintain staffing government mane are open shifts for nursing or nursing will make every elected performance Imparts and the procedure will be a cover an open shifts at the procedure will be a cover an open shifts and develop fall incidents. The those findings/ed performance Imparts and to ensure the procedure will be a cover and t	Indeprocedure Open Shift Staffing (16, included):  In the safety and quality of care is the policy to consistently evels that are at or above the dates. Therefore when there is any reason on the licensed grassistant schedule, the facility effort to fill the open shifts the time the schedule is posted or exchedule is posted in the or nursing assistant department equesting employees to fill such pluntary basis. If a replacement collowing open shift staffing utilized is shall designate by an * the each shift who will be expected to fit after all efforts to fill a en exhausted. Employees shift immediately preceding and shift will be expected to cover 4 shift. However, if open shifts and after a designated such employee will not be both shifts.  ETHOD OF CORRECTION: The grown of the director of nursing develop a system to educate a monitoring system related to DON or designee could take ucation to the Quality Assurance rovement (QAPI) committee for ount of time until the QAPI nines successful compliance or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00619	B. WING			C I <b>1/2023</b>
	PROVIDER OR SUPPLIER	640 THIRE		STATE, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa TIME PERIOD FOF (21) days.	ge 38 R CORRECTION: Twenty One	2 830			
2 885	Subpart 1. Programmust have an active nursing care directed resident to achieve practicable physical well-being according resident assessment in parts 4658.0400 efforts must be made and purposeful act.  This MN Requirement by: Based on interview review, the facility fawalking program to 1 of 1 residents (R1 services.  Findings include:  R12's face sheet prodiagnoses of cerebothat impact the blood dayarthria (speech weakness of the michemiplegia and her diabetes mellitus with damage) and weak R12's significant chemiplegia and weak R12's significant chemiplegi	n required. A nursing home e program of rehabilitation ed toward assisting each and maintain the highest I, mental, and psychosocial g to the comprehensive ent and plan of care described and 4658.0405. Continuous de to encourage ambulation ivities.  ent is not met as evidenced ent is not ent is not met as evidenced ent is not ent is not met as evidenced ent is not e	2 885	Corrected		6/30/23

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00619	B. WING			C   <b>1/2023</b>
	PROVIDER OR SUPPLIER	640 THIRI	DRESS, CITY, S D STREET D, MN 55334	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	rejection of care and dressing, personal by transfers. Walking of R12's care plan datactivities of daily living and required minimic walker for transfers ambulation. R12 with gait belt and frow the right hand on the right hand on the right hand on the During interview on stated when she first walk with one foot, stated she would like staff don't take her was currently in the a recent Covid-19 in Interview on 5/8/23 (FM)-C stated staff legs were to weak a wasn't safe.  During observation was in her wheelchair in her walked her.	deficit, no behaviors including dextensive assist of one for hygiene, toileting and on and off unit did not occur.  ed 4/3/23, indicated an ing (ADL) performance deficit al assist of 1 with gait belt and inderate assist of 1 for as to ambulate 2 times daily ont wheel walker with behind (2 people). Support to a wheeled walker.  5/8/23 at 9:42 a.m., R12 at got to the facility she could but now she was to weak. R12 at to walk in the hallway but for a walk. R12 added she rapy related to weakness from infection.  at 2:31 p.m., family member were not walking R12 as her and staff had indicated it  on 5/10/23 at 1:13 p.m., R12 air and used one leg to wheel				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		` ′	3) DATE SURVEY COMPLETED	
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00619	B. WING		05/1	1/2023	
NAME OF PROVIDER OR SUPPLIER STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
BAYSIDE MANOR LLC	D STREET D, 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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
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		DEFICIENCY)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE S  COMPL		E SURVEY PLETED	
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	00619	B. WING			11/2023
NAME OF PROVIDER OR SUPP	LIER STREET AD	DDRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE MANOR LLC		D STREET D, MN 55334			
(X4) ID SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
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2 885 Continued From	n page 41	2 885			
3/3/23 through Walk in hallway out of possible times requiring Walk in room: attempts. Walk limited to extern Interview and of a.m., R12 was in her wheelche back to her room more and felt somuch. R12 add she used the wand was "stuck During interview stated they have	t of care ambulation record from 4/16/23, included:  Y: Not applicable (NA) 86 times 90 attempts. Walking occurred 4 limited to extensive assistance.  NA 87 times out of possible 90 ing occurred 3 times requiring sive assistance.  Servation on 5/11/23 at 8:57 in the dining room eating breakfast air. R12 used one leg to wheel self m. R12 stated she wanted to walk he was in the wheelchair too led when she came to the facility alker and now she doesn't at all " in this wheelchair.  Y on 5/11/23 at 9:04 a.m., NA-C e walked R12 in the past but as working with therapy and were				
therapy aide (Foundation working with Royal 4/16/23. PTA-E at that time and assist. PTA-E at walking prog	11/23 at 9:06 a.m., physical TA)-E stated therapy started 12 after she had Covid-19 on indicated she was an assist of 2 was currently in between 1 and 2 stated R12 was supposed to be on am prior to this and if staff were they should have been.				
assistant (NA)- were walking F she was not or	11/23 at 10:38 a.m., nursing B stated she did not think they 12 at all since she was admitted, an ambulation program.				
	11/23 at 1:07 p.m., the director of stated PT left recommendations				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	OF COTTLECTION	IDEITH IO/THONIBEIT.	A. BUILDING:			
		00619	B. WING			C I <b>1/2023</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE	E MANOR LLC	640 THIRE	STREET			
		GAYLORD	), MN 55334	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT) CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 885	there shortly after send of March, aske staff were unsure. process was put into by the interdisciplination realistic expectation was standard when resident either the nurse or least the standard when the standa	en she saw R12's order sitting he started at the facility at the d staff what happened next, The DON stated a new to place that included review ary team (IDT). IDT evaluated ations and then care planned. The DON included her aff would complete the task refused, it was reported to her, and documented.	2 885			
	The director of nurseall residents at risk they are receiving the treatment/services from developing an pressure ulcers. The designee, could condelivery of care; to services are implementated audits could be brocommittee for review	to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for elopment. The results of the ught to the quality assurance				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE	
		71. BOILBING.	7t. Boilebiito.		
	00619	B. WING		05/11	/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE MANOR LLC	640 THIRE GAYLORD	D STREET ), MN 55334			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900 MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		(	6/30/23
comprehensive res	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
receives necessary	ho has pressure sores  I treatment and services to revent infection, and prevent reloping.				
by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to comprehensively pressure ulcer (PU) for 1 of 1 was diagnosed with pressure admission from the hospital.		Corrected.		
Findings include:					
diagnosis of fracture pulmonary fibrosis and stiffens), fractures of multiple fractures of	inted 5/11/23, included e of neck of left femur, (lung tissue scars, thickens re of left pubis (pelvic bone), f ribs right side, heart failure, n (abnormal growth of tissue) epeated falls.				
R21's significant ch	ange Minimum Data Set				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7 1.2			A. BUILDING:		
		00619	B. WING		C 05/11/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
BAYSIDE	E MANOR LLC	640 THIRE	STREET		
		GAYLORD	), MN 55334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 900	Continued From pa	ge <b>44</b>	2 900		
2 900	impairment, and de inattententiveness to Activities of daily live assist of 2 persons personal hygiene as pressure ulcers but R21's current care 3/23, indicated impatto immobility with care advanced age, term Interventions include 2-3 hours, encourage hydration in order to identify/document peliminate/resolve we protocols for treatment An Incident Review 1/29/23 at approxime R21 was found on the left side and bathe emergency depend admitted with a R21 returned to the hospice services.  A hospital discharge indicated principal of femur with active proheart failure and free intervention on 1/30 complicated by increase and return the art rate. After discharge indicated principal of femur with active proheart failure and free intervention on 1/30 complicated by increase and admitted with active proheart rate. After discharge indicated principal of femur with active proheart failure and free intervention on 1/30 complicated by increase and admitted with active proheart rate. After discharge indicated by increase and admitted with active proheart rate. After discharge intervention on 1/30 complicated by increase and admitted with active proheart rate. After discharge indicated principal of the proheart rate. After discharge in the proheart rate. After discharge in the proheart rate.	B, indicated severe cognitive dirium which included that comes and goes. ing (ADL's) included extensive for transfers, bed mobility, and toileting. R21 was at risk for a had no skin issues currently.  I plan dated 2/2/23, last revised airment to skin integrity related occyx wound related to airment illness and fragile skin. I led: turn and reposition every ge good nutrition and oppromote healthier skin, totential causative factors and here possible. Follow facility tent of injury.  I and Analysis form dated the floor in her bathroom on ck. R21 was transferred to artment (ED) via ambulance liagnosis of left femur fracture. I facility on 2/2/23, with  I summary dated 2/2/23, with  I summary dated 2/2/23, diagnosis of fracture of neck of roblems listed as renal mass, equent falls. R21 had surgical 2/23. Recovery was leased confusion and rapid cussion with the family, and comfort care was			
		a Collection form dated 2/2/23 censed practical nurse			

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	NT OF DEFICIENCIES I OF CORRECTION					
		00619	B. WING		05/1	) 1/2023
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC  STREET ADDRESS, CITY, STREET ADDRESS, C						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	activity level and activity assessment include incision intact with areas of bruising rewith several bruises Collection form lackinjury. Further, the comprehsive skin atime of re-admission A progress note dat (MP)-L, indicated R surgical repair on 1/2 significant delirium hospice upon return R21 had been lethatime. R21 had no reexposed skin. Has hip incision with no Anticipate progress focused care.  R21's weekly skin in registered nurse (R the coccyx area and buttock, 2.0 x 2.6 cm buttock, 2.6 cm on coospine). Left lateral buttock intact blister. Right lateral buttock of the coccyx. Work a wound care constructed in the coccyx. Work and care constructed in the coccyx and	m., indicated a change in tivities of daily living (ADL) Foley catheter in place. Skin ed left trochanter (hip) surgical 15 staples, face with several lated to fall and bilateral arms is noted. The Readmit Data ared evidence of deep tissue record lacked evidence a ssessment was completed at in.  Med 2/7/23, by medical provider 21 had left hip fracture with 1/30/23. R21 experienced post-op and was enrolled in in back to the facility on 2/2/23. Argic and sleeping most of the ishes, wounds or lesions to extensive facial bruising, left redness or drainage. The inverse decline with comfort in spection on 2/8/23, by N)-A removed a mepliex from the noted a blister on left in, with abrasion on left lower in. Unstageable purple area arecyx (most distal portion of the buttock has a 2.6 x 1.0 cm buttock had an area of	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		00619	B. WING		05/1	) 1/2023
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	1/2020
		640 THIRE		517(TE, 211 OOBE		
BAYSIDE	E MANOR LLC	GAYLORD	, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge <b>46</b>	2 900			
	PN-A indicated constraints of serosanguious (pred blood cells typic heal) drainage note.  Wound evaluation from the indicated coccyx with unstageable 6 x 4 x (layer of dead tissue included wound bed	orm dated 2/17/23, LPN-A th pressure wound, 0.2 depth with 100% slough e) present. Description was grayish slough with				
	appearance. Providorders for wound calginate silver to wo	igh around edges. Moist in er was updated with new are. MP-M to place calcium and bed and cover with a dressing three times a week				
	2/21/23, MP-M indic	ultant progress note dated cated coccyx pressure ulcer x 0 with light serosanguinous				
	indicated unstageal	orm dated 2/22/23, LPN-A ole coccyx wound 11 x 8 x 0 0% necrotic with light ninage.				
	indicated stage 4 comproving. Wound undermining presendrainage. 35% necregranulation. No bonfree of slough, necremuscle/fascia level.					
	drainage. 35% necregranulation. No bonfree of slough, necrember muscle/fascia level.	otic tissue and 65% e visible. Wound is almost otic tissue. Does expose				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMP	SURVEY	
		00619	B. WING		05/1	) 1/2023
BAYSIDE MANOR LLC			DRESS, CITY, S D STREET D, MN 55334	STATE, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Most recent consult dated 5/4/23, MP-M remain in place. For tissue injury evolved Wound was improved 0.7 x 1.2. Moderate continued with 100% exposed but no bor improve week over.  Most recent wound indicated a stage 4 0.7 x 0.3 with 100% healing, no bone ex and no pain noted. Cleanse with Vashe gauze and allow to minutes with each of prep to wound edge calcium alginate. Concept to wound edge calcium alginate.	ing wound MP-M and LPN-A ng.  ing wound care progress note indicated hospice services llow up management of deep d to stage 4 pressure ulcer. ing with measurements of 3 x serosanguinous drainage granulation with muscle le. Wound continued to week.  evaluation 5/5/23, LPN-A pressure ulcer on coccyx 3 x granulation. Wound was posure with minimal drainage Current intervention include wound cleanser. Moisten remain on wound bed for 3-5 dressing change. Apply skin les. Pack wound with silver over with silicone foam border have times per week and as leasures elements of risk for sesure ulcers) was completed	2 900			

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AND PLAN OF CORRECTION	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:				
	00619	B. WING		05/1	) 1/2023
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC	640 THIRI	DRESS, CITY, S D STREET D, MN 55334	STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
and was transferred her left side.  Observation on 5/10 hollering out for help bed. The director of assistant (NA) responses transferred back common room. R21 common room until assisted R21 back to changed and settled.  Interview on 5/10/23 she assessed the way upon return and assisted as complete skin confirmed she did not upon return so was was present on admitted with a sore dressing was present admitted with a sore dressing was present on initially returned. Not every 2 hours.  Interview on 5/11/23 indicated she wasn't her coccyx or dress returned from the head of the coccyx or dress returned from the coccyx or dress returned from the coccyx or dress ret	com after attending activity of to her bed and was lying on 20/23, at 4:43 p.m. R21 was p and began to climb out of inursing (DON) and nursing conded immediately and R21 ck to her chair and out to the remained in wheelchair in 6:15 p.m. when an aide to her room, checked and dinto bed on her right side.  3, at 3:30 p.m., LPN-A stated rounds she could visualize sumed the nursing staff would check upon admission. LPN-A not observe the coccyx area unsure if deep tissue injury hission or not.  3, at 10:20 a.m., NA-C of tremember if R21 was e on her coccyx or if a not. NA-C added they were ery 1-2 hours when she ow they are doing at least as at 10:40 a.m., NA-B t sure if R21 had a sore on ing present when she ospital. NA-B added she ght shift and they were	2 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00619	B. WING	B. WING		) 1/2023
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	1/2020
		640 THIRE	, ,	717 (T E , Z III - G G B E		
BAYSIDE	E MANOR LLC	GAYLORD	), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge <b>49</b>	2 900			
	She confirmed one upon re-admission.	was not completed for R12				
	registered nurse (R the admission nurse R21's record and in documentation ther documentation preserving bruise, surgical incise Documentation include every two hours and on admission.  Interview on 5/12/23 she was not sure if the wound present admission. MP-L at the health condition to say if the wound facility or if it was preserved.	8, at 3:53 p.m., with hospice N)-B indicated she was not e for R21. RN-B reviewed dicated on 2/2/23 admission e was no coccyx wound sent but facial areas with sion on hip was present. Uded important to reposition d an air mattress was ordered at 8:29 a.m., MP-L indicated the resident was admitted with or if it occurred after dded given R21's health and she returned in, it was difficult began in the hospital or at the reventable. MP-L added staff R21 every 1-2 hours and the present advocating for				
	policy and procedure.  A pressure ulcer riscompleted for every (Braden Scale).  Staff will perform redaily care.  Nurses are to be need identified.  A weekly skin inspector.	and Wound Management re dated 5/27/22 included: sk assessment will be resident upon admission outine skin inspections with otified if skin changes are ection will be completed by				
	The director of nurs	HOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		B. WING		C		
	00619	B. WING		05/1	1/2023	
NAME OF PROVIDER OR SUPPLIER		,	STATE, ZIP CODE			
BAYSIDE MANOR LLC	640 THIRE GAYLORD	) STREET ), MN 55334				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
necessary treatment ulcers from develop pressure ulcers. The designee, could condelivery of care; to eservices are implementated pressure ulcer developmentate audits could be broad committee for review TIME PERIOD FOR (21) days	assessed and receiving the t/services to prevent pressure ing and to promote healing of the director of nursing or aduct random audits of the ensure appropriate care and nented; to reduce the risk for elopment. The results of the light to the quality assurance w.	2 900				
Subp. 6. Activities of comprehensive resistance in the must ensure B. a resident who activities of daily living services to maintain and personal and of the most	is unable to carry out ng receives the necessary n good nutrition, grooming, ral hygiene.  ent is not met as evidenced on, interview and document ailed to ensure dependent esistance with personal es of daily living (ADL's) for 2 R15) who were dependent on rgiene.	2 920	Corrected.		6/30/23	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00619	B. WING		1	C 1 <b>1/2023</b>	
NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC	640 THIRE		STATE, ZIP CODE			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
and personal hygier rejected care behave pulmonary fibrosis (tissue to scar, thicked disease, anxiety, spentification with neurogenic class compressed in the labips, depression, at R8's care plan dates self-care performant pulmonary fibrosis, spinal stenosis of luclaudication, osteoa dementia; interventi (assist of one) with eating,); shower/bathospice, Saturday plassistant).  R8's progress notes refusal of care.  On 5/08/23 at 1:41 white and black chir (approximately ½ in her chin hairs shave stated shaving was staff.  On 5/09/23 at 10:12 seated in a wheelch chin hairs visible. No R8's morning cares shift.  On 5/10/23 at 10:14 (DON) stated shaving was staff.	ansfer, dressing, toilet use, ne; utilized a wheelchair; no liors. Diagnoses included: lung disease that causes lung en, and stiffen), Alzheimer's inal stenosis of lumbar region udication (spinal nerves get ower spine), osteoarthritis of	2 920				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00619	B. WING		C 05/11/2023	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/11	
			D STREET			
BAYSIDE	E MANOR LLC	GAYLORE	D, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From page	ge 52	2 920			
	hair shaved. The Dowere long and need staff had not complete (TMA)-A stated staff were expected to shair was visible. TM	ne DON she wanted the facial ON confirmed R8's chin hairs led shaving and confirmed eted the task for R8.  S a.m., trained medication aide if who provided morning cares have the residents when facial IA-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.					
	4/18/20/23, indicate impairment; require with bed mobility, dresonal hygiene, to transfer, and utilized included: heart failure	imum Data Set (MDS) dated d severe cognitive d one-person physical assist essing, eating, toilet use, wo person physical assist with d a walker. Diagnoses re, Alzheimer's disease, weakness, and history of				
	self-care performandementia, heart fail resident will be near assistance from state extensive A1 with describing and eats slow.  On 5/08/23 at 9:35	ed 5/10/23, indicated an ADL ace deficit r/t Alzheimer's, ure, COPD, weakness; t, clean and odor free with ff. Interventions included ressing and grooming; athing; eating independent out for meals to dining room, a.m., R15 was lying in bed d had not eaten breakfast.				

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NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC  SUMMARY STATEMENT OF DEFICIENCIES  GAD THIRD STREET GAYLORD, MN 55334    PREFIX FEED   SUMMARY STATEMENT OF DEFICIENCIES   GAPLORD, MN 55334    PREFIX FEED   SUMMARY STATEMENT OF DEFICIENCIES   GAPLORD MN 55334    PREFIX FEED   SUMMARY STATEMENT OF DEFICIENCIES   GAPLORD MN 55334    PREFIX FEED   SUMMARY STATEMENT OF DEFICIENCIES   GAPLORD MN 55334    PREFIX FEED   GAPLOR FIGURE OF MN 518 ET PRECEDED BY FILL   PREFIX TAG   GAPLOR FILL OF MN 518 LET PRECEDED BY FILL   PREFIX TAG   GAPLOR FILL OF MN 510 LD BE   CROSS-REFERENCE D TO THE APPROPRIATE   DATE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED	
BAYSIDE MANOR LLC  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  On 5/08/23 at 12:32 p.m., observed NA-C enter R15's room, changed R15's biref and walked with R15 through the hallways and proceeded to the dining room for lunch. NA-C stated she was unaware if R15's morning cares were today.  On 5/08/23 at 12:32 p.m., observed NA-C enter R15's room, changed R15's biref and walked with R15 through the hallways and proceeded to the dining room for lunch. NA-C stated she was unaware if 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			00619	B. WING		1	
CASIDE MANOR LLC   CAYLORD, MN   55334	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  REGULATORY OR USC IDENTIFYING INFORMATION)  2 920  Continued From page 53  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 no 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 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	BAYSIDE	E MANOR LLC					
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On 5/11/23 at 11:41 a.m., R15 was seated in the	2 920	On 5/08/23 at 12:32 R15's room, change R15 through the hadining room for lund unaware if R15 was or ate breakfast. Naresponsibility R15's  On 5/08/23 at 3:48 had not provided R15 was shower.  On 5/10/23 at 1:31 5/8/23, she arrived and R15's morning provided prior to he  On 5/11/23 at 9:22 awere expected to as cares. Residents we bed at 10:00 a.m.  On 5/11/23 at 9:48 abed under the coveron for S/11/23 at 10:35 (LPN)-A stated here confirmed R15 was morning cares todar on 5/11/23 at 10:37 not had time to comtoday. NA-B stated for ADL cares and whereakfast already.	2 p.m., observed NA-C entered R15's brief and walked with always and proceeded to the ch. NA-C stated she was a provided morning ADL cares A-C was unsure whose morning cares were today.  p.m., the DON confirmed staff 15 morning cares or breakfast e disruption of the schedule behind with morning cares. as provided an afternoon  p.m., NA-A confirmed on at work around 12:00 p.m. cares nor breakfast had been right.  a.m., the DON stated staff esist residents with morning ere not expected to still be in a.m., R15 was observed in herms.  a.m., licensed practical nurse shift "just" started and not assisted with breakfast or y.  a.m., NA-B verified she had aplete R15's morning cares R15 was dependent on staff was expected to have had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>l</b> `´´		(X3) DATE SURVEY COMPLETED	
	00619	B. WING			C 1 <b>1/2023</b>
PROVIDER OR SUPPLIER	640 THIRI	DSTREET			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETE DATE
Facility policy titled (ADLs)/ Maintain At indicated:  Intent: It is the policy responsibility to cree environment that he each resident's qual across all shifts and principles of quality these principles for care and services pand honor and supporterences, choice 3. The facility will provide the following activities and honor and supporterences, choice 3. The facility will provide the following activities and honor and supporterences, choice 3. The facility will provide the following activities and honor and supporterences, choice 3. The facility will provide the following activities and honor and supporterences and honor and supporterences. Speech functional communities of daily living will reduce to maintain good numbers on all and or all honor and supportered to maintain good numbers on all and or all honor and supportered to maintain good numbers on all and or all honor and supportered to maintain good numbers on all and or all honor and supportered to maintain good numbers on all and or all honor and supportered to maintain good numbers on all and or all honor and supportered to maintain good numbers on all and or all honor and supportered to maintain good numbers on all and or all honor and supportered to maintain good numbers on all and or all honor and supportered to maintain good numbers on all the factors and the factors of	Activities of Daily Living bilities Policy dated 3/31/23, by of the facility to specify the late and sustain an imanizes and individualizes lity of life by ensuring all staff, if departments, understand the lof life, and honor and support each resident; and that the provided are person-centered, bort each resident's les, values and beliefs.  Hovide care and services for les of daily living: a. Hygiene grooming, and oral care, b. di ambulation, including lon-toileting, d. Dining-eating, di snacks, e. Communication, ii. Language, and iii. Other cation systems.  Language, and iii. Other cation systems.  Language, and life support, and basic life support, and the resident requiring such or to the arrival of emergency and subject to related dithe resident's advance.	2 920			
review applicable po	olicies and procedures on				
	PROVIDER OR SUPPLIER  MANOR LLC  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS  Continued From particular dividing room and ate facility policy titled and (ADLs) / Maintain Att indicated:  Intent: It is the policy responsibility to cree environment that he each resident's qual across all shifts and principles of quality these principles for care and services pand honor and supperferences, choice  3. The facility will provide the following activitity bathing, dressing, and Mobility-transfer and walking, c. Eliminating including meals and including meals and including including including including including including including community.  4. A resident who is of daily living will red to maintain good nupersonal and oral he including CPR, when the emergency care primedical personnel and physician orders and directives.  SUGGESTED MET director of nursing (review applicable personnel and orders and directives).	OF CORRECTION  O0619  PROVIDER OR SUPPLIER  STREET AD  640 THIRI GAYLORE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 54  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	OF CORRECTION  DO619  STREET ADDRESS, CITY, 8 640 THIRD STREET GAYLORD, MN 55334  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 54  dining room and ate breakfast.  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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	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET GAYLORD, MN 55334  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 54  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 each resident; and that the care and support each resident; and that the care 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 meals and snacks, e. Communication, including meals and snacks, e. Communication, including moderation of the provide care and services for the following activities of daily living; and opersonal 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	OF CORRECTION  O0619  B. WING  B. WING  O0679  STREET ADDRESS, CITY, STATE, ZIP CODE  640 THIRD STREET  GAYLORD, MN 55334  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  COntinued From page 54  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, 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-to-lelling, d. Dining-eating, including in Reals and snacks, e. Communication, including: 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's advance directives.  SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			SURVEY LETED	
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		00619	B. WING	B. WING 0		1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE	MANOR LLC	640 THIRE GAYLORE	D STREET D, MN 55334			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 NC	(X5)
PRÉFIX TAG	•	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE
2 920	Continued From pa	ge 55	2 920			
		accuracy; then educate staff ongoing compliance.				
	TIME FRAME FOR (21) days	CORRECTION: Twenty-one				
21015	MN Rule 4658.0610 Requirements- Sar	Subp. 7 Dietary Staff nitary conditi	21015			6/30/23
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure dishwashing propriately monitored and rage of food brought in for, or afe for consumption. This had ct all residents in the facility.		Corrected.		
	Findings include:					
	UNLABELED AND	UNDATED FOOD				
	kitchenette located to residents, family in from outside the and beverages obsincluded the following. Thick it advantage and labeled expired 2. Lyon prune juice empty with expiration	ge for coffee, opened, undated 1/21/24. opened and undated, 3/4				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  BAYSIDE MANOR LLC    XA,    D		TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES   TABLE   SUMMARY STATEMENT OF DEFICIENCIES   CRACH DEFICIENCY MUST BE PRECEDED BY FULL   TABLE   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY   DEFI			00619	B. WING		_	
CAYLORD, MN 55334   CAYLORD, MN 55334   CAYLORD, MN 55334   CAYLORD, MN 55334   CAYLORD   CAYLORD CORRECTION   CAYLORD CAYLORD CORRECTION   CAYLORD CAYLORD CORRECTION   CAYLOR	NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
PREFIX TAG  REQULATORY OR LSC IDENTIFYING INFORMATION)  21015  Continued From page 56 that appeared shriveled, undated and unlabeled. 4. 1 storage bowl that contained a shrimp salad, undated and unlabeled and unlabeled and unlabeled. 5. A chocolate pudding dessert on a cookie sheet 3/4 empty covered with tin foil unlabeled 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 reffigerator was for residents only. Residents were to date and label the food they put in there. C-A was unsure who monitored the reffigerator.  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,	BAYSIDE	MANOR LLC					
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 fin 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,	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
nutritious, healthy food productsIf a resident's family's should bring in food for their loved one, and this food can be stored in a		that appeared shrive 4. 1 storage bowl the undated and unlabe 5. A chocolate pude 3/4 empty covered wandated. 6. 2 salad dressing unlabeled 1/2 empty Multiple other bever  During interview on (C)-A indicated the conly. Residents we they put in there. C- the refrigerator.  On 5/9/23 at 7:33 at expired foods listed kitchenette refrigerat  Interview on 5/11/23 refrigerator in the di today and items not discarded including containers. C-B con were stored in the re residents foods. C-E should be labeled we All facility products we opened. If unlabled discarded.  A facility policy and into a Monarch Hea dated 4/97 included -Purpose is to provinutritious, healthy for -If a resident's famili	eled, undated and unlabeled. nat contained a shrimp salad, eled. ding dessert on a cookie sheet with tin foil unlabeled and  bottles undated and y. No expiration present. ages unopened were present. 5/9/23 at 11:01 a.m., cook refrigerator was for residents re to date and label the food A was unsure who monitored  m., opened, undated and above remained in the ator.  at 9:35 a.m., C-B stated the ning room was cleaned out labeled or dated were the 2 storage bowl firmed beverages for meals efrigerator along with confirmed all resident foods with resident name and dated. were labeled with date or undated, should be  procedure for Food brought lthcare Management Facility de each resident with safe, bod products. y's should bring in food for	21015	DEFICIENCY		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAIN	OF CORRECTION	IDENTIFICATION NOIVIBER.	A. BUILDING:		COMPLETED	
		00619	B. WING		C 05/11/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DAVCIDE	E MANOD LL C	640 THIRI	STREET			
BATSIDE	E MANOR LLC	GAYLORE	), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 57	21015			
	accept this and mo	nitor the use.				
	kitchen and dishwa dishwasher was a d was rented. The re- products and check	terview on 5/9/23 at 10:39				
	a.m., C-C ran dirty dishwasher. C-C st dishwasher but she with any chemical sopposite wall that in Temperature Log (Loclumn for wash te Fahrenheit (F) and million) 50-100. C-C temperature of the documented results had a hard time see Next to the clip boar Chlorine Strips. C-C they were for and the them on dishwasher C-C then went into PH (a figure express a solution) strips and dishwasher PH white reading). C-C attention turned a blue color	dishes through the ated it was a low temperature did not check the dishwasher strips. A clip board hung on the acluded a Dishmachine Low temperature). It included a amperature 120-140 degrees Chlorine PPM (parts per C stated they documented the wash and rinse cycles and son that form. C-C added she eing the temperature gauge. It was a container labeled C stated she did not know what he last time she tried to use er, the strip remained white. In another room and brought out asing the acidity or alkalinity of alkalinity of hid attempted to check ch turned the strip white (no apted the chlorine strips which indicting 50 PPM of chlorine.				
	indicated the rinse on the Dishmachine rinse temperature. attempted testing depth PH paper white (no	5/9/23 at 10:50 a.m., C-A 50-100 PPM chlorine column e Temperature Log was the C-A got PH Paper and ishwasher which turned the t an actual reading). When strips, C-A stated she had not				

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Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		00619	B. WING		05/11	/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BAYSIDI	E MANOR LLC		D STREET D, MN 55334			
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	he was not aware of dishwasher needed Dishmachine Temp procedure titled Dischecking the temper was 150-160 degree water was 180 degree water was 180 degree water was 180 degree policy of the fact to be changed to the and procedure.  Interview on 5/11/23 proper policy and procedure today.  A policy and procedure today.  Low temperature 150-165 degrees Frinse temperature 1 seconds.  -Low temperature desanitization) wash to and final rinse with seconds.  SUGGESTED MET The dietary manage administrator, could control technique remaintained in the king the seconds in the king technique remaintained in the king technique remai	at 12:55 p.m., C-B indicated f the chemical strips and the to be tested. Behind the erature Log was a policy and hwasher which included erature to insure wash water es Fahrenheit (F) and rinse rees F. Record temperature fility. C-B indicated it needed e chemical dishwasher policy at 9:35 a.m., C-B stated the rocedure for dishwasher low ical sanitization) was located. properly educated on the				
	competencies. The	ese changes and perform dietary manager, registered strator could perform audits				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00619	B. WING		C 05/11/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	<u>-</u>	
		640 THIRI	,	- · · · · -, - · · · · · · · · · · · · ·		
BAYSIDE	MANOR LLC	GAYLORE	), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) OMPLETE DATE
21015	Continued From pa	ge 59	21015			
	could report audit find Performance Improrections a	re compliance. The facility ndings to Quality Assurance vement (QAPI) for further and to determine compliance.				
	(21) days.					
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients & ic.Bill of Rights	21805		6/3	30/23
	residents have the courtesy and respec	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observation review the facility fac	ent is not met as evidenced on, interview and document iled to provide a dignified or 4 of 4 residents (R24, R15, equired supervision and ng.		Corrected		
	Findings Include:					
	and R3 sat at one to them with food just the next table with f R3, R24 and R15 m Trained medication R26 to assist with m offered to R24, R15 TMA-A indicated to and went to the nurs	on 5/8/23, at 12:27 p.m., R26 able with beverages in front of delivered. R24 and R15 sat at food delivered at 12:25 p.m. nade no attempt to eat. assistant (TMA)-A sat with neal. No encouragement was for R3 to eat. At 12:43 R26 she would be right back ses station and began passing :52 p.m. nursing assistant				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00040	B. WING		C	
		00619	D. WING		05/1	11/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	, ,	STATE, ZIP CODE		
BAYSIDE	E MANOR LLC		), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	R3 and assisted R3 NA-A went to the net forkful of hamburge R24 to take a bite be NA-A went to kitcher returned, and while bite of food. She we of food, which she as R26 attempted to go was not successful back to R3 and gave vegetables. At 12:5 and attempted to gishe again refused. At 1:00 p.m., NA-A returned at 1:03 p.m. R26 and R3, both rewent to kitchen area with a spoonful of diable, encouraged Fp.m., NA-A left the fimade no further attempted to be reheat throughout meal prostaff present in the diagnoses of Alzhei (difficulty in swallow R24's quarterly, Mirassessment, dated cognitive impairmer one person to physical R24's care plan data.	dining area and stood next to with a forkful of vegetables. ext table, assisted R15 with a protection of the protection	21805			
	altered diet and req	uires supervision to limited to				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		00619	B. WING		C 05/11/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	•
INAIVIL OI I	FINOVIDEN ON SUFFLIEN		D STREET	STATE, ZIP CODE	
BAYSIDE	E MANOR LLC		D, MN 55334		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX TAG	`	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE
21805	Continued From pa	ge 61	21805		
	extensive assist, re	quiring 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.				
	-	ed 4/25/23, indicated an es of daily living and required with eating.			
		ord, printed 5/11/23, identified eimer's disease, and vioral disturbance.			
		ated 3/1/23, indicated severe nt and required supervision of I assist with eating.			
	R3's care plan date	d 3/1/23 indicated an activities			

Minnesota Department of Health

	AND BLAN OF CORRECTION TO THE IDENTIFICATION NITIMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
		00619	B. WING	B. WING		/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE	•	
	E MANOR LLC	640 THIRE	STREET			
		GAYLORL	), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDER DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From page	ge 62	21805			
	of daily living deficit setup and cues and	and requires supervision with assist as needed.				
	stated there were of noon when she arrived in the dining room to from the other nursing stated there were two feeding at one table supervision and end	on 5/8/23, at 2:31 p.m., NA-A nly two NA's in the facility until yed. She called for assistance wice without any response ng staff members. NA-A vo residents that required and the other two require couragement to eat. NA-A more help in the dining room				
	director of nursing (5/8/23, staffing was unaware the facility confirmed NA's were assisting residents v	5/10/23 3:08 p.m., the DON) stated on Monday a challenge as she was was short. The DON e expected to sit while with meals and food should be ng longer than 5-10 minutes.				
	director of nursing (ensure policies and dignified dining are nursing (DON) or deappropriate staff on related to dignified (DON) or designee	HOD OF CORRECTION: The DON) or designee could procedures related to correct. The director of esignee could educate all the policies and procedures dining. The director of nursing could develop monitoring ongoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21830	MN St. Statute 144. Residents of HC Fa	651 Subd. 10 Patients & c.Bill of Rights	21830			6/30/23
	Subd. 10. Particip	ation in planning treatment;				

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00619	B. WING		05/1	) 1/2023
		00019			05/1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSID	E MANOR LLC	640 THIRE GAYLORE	O STREET O, MN 55334	•		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21830	Continued From pa	ge 63	21830			
	notification of family	members.				
	in the planning of the includes the opportunity alternatives with independent of alternatives with independent of alternatives with independent of a care conferences, a family member or or both. In the event the present, a family member of conferences.  (b) If a resident we unconscious or concommunicate, the facility and either a family member of a family member to be planning, unless the to believe the resident directive to the context of the context of the family member included in notifying a family member to perforts, consistent we practice, to determine the executed an advance of the care of th	I have the right to participate eir health care. This right unity to discuss treatment and lividual caregivers, the est and participate in formal and the right to include a ther chosen representative or hat the resident cannot be ember or other representative ent may be included in such who enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify aber or a person designated in ent as the person to contact in the resident has been entered in the facility knows or has reason ent has an effective advance erary or knows the resident has that they do not want a family a treatment planning. After ember but prior to allowing a carticipate in treatment or must make reasonable with reasonable medical effective relative to the edecisions. For purposes of asonable efforts" include: e personal effects of the ession of the facility;				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		00619	B. WING		C 05/11/2023
NAME OF PROVIDE	R OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	
TV/ (IVIL OF T TO VIDE)	CORCOL LILIC		D STREET	517(TE, ZII OOBE	
BAYSIDE MANO	R LLC		), MN 55334		
	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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
21830 Contin	ued From pa	ge 64	21830		
(3) if family whether directing physics care; at (4) if reside whether directing design members according to the notion emerging admission and the possest of notion emerging admission emerging admission and the possest of notion emerging admission emerging	nquiring of an member conder the resider ve and wheth ian to whom and nquiring of the resider ve. If a facility at each contact member was a member or designating the person of the facility shall attempt the resident received and the facility shall attempt to a family member or designation, the facility has been a service agency or lease agency or	ny emergency contact or tacted under this section at has executed an advance er the resident has a the resident normally goes for e physician to whom the oes for care, if known, at has executed an advance y notifies a family member or ncy contact or allows a family ate in treatment planning in s paragraph, the facility is not a damages on the grounds that he family member or or the participation of the improper or violated the			

Minnesota Department of Health

	AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED	
		00619	B. WING		O5/11	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDE	E MANOR LLC		D STREET D, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
21830		ge 65 ounds that the notification of or emergency contact or the	21830			
	,	family member was improper				
	by: Based on observati	ent is not met as evidenced on, interview and document		Corrected.		
	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:					
	3/20/23, indicated Find impairment and der or other behavioral two-person physical transfer, toilet use; with dressing, person and wheelchair. Dia urinary incontinence (breakdown of joint bone), and heart fail					
	(activity daily living) r/t (related to) heart of the hips, trochant bilateral primary ost cognitive impairment neat, clean, and ode staff; maintain curre extensive A1 (assist grooming, bathing,	ed 3/27/23, indicated ADL self-care performance deficit failure, bilateral osteoarthritis teric bursitis left hip, obesity, teoarthritis of knee, and at. Interventions included: or free with assistance from ent level of function; and tof one) with dressing, and eating. Get resident up on and prefers to be up in dining				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		00619	B. WING		05/1	C 1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DAVSIDE	E MANOR LLC	640 THIRI	,			
BATSIDE	E MANOR LLC	GAYLORE	), MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 66	21830			
	room around 6:00 a	ı.m.				
	information manage "Writer was helping with resident to see to talk to someone a get up early, betwee breakfast early per today until at least 1 10:30 and eluded to more than once rec I would notify the ap the plan is followed and checked with re needed. He wanted fact that he wants to 5:30 and have brea He was in bed today get to eat until 10:30 has happened more assured him that I w people to ensure the Progress note dated licensed practical ne stated "I want to get go out for breakfast make it on time."  Grievance summary had requested to get a.m., was still not up at 10:15 a.m., and to Grievance indicated was placed on the of	d 5/4/23 at 2:31 p.m., health ement (HIM)-F indicated, check call lights and checked what he needed. He wanted about the fact that he wants to en 5 and 5:30 and have his care-plan. He was in bed 10 and did not get to eat until of the fact that it has happened ently. Writer assured him that oppopriate people to ensure was helping check call lights esident to see what he to talk to someone about the orget up early, between 5 and kfast early per his care-plan. If y until at least 10 and did not 20 and eluded to the fact that it is than once recently. Writer would notify the appropriate e plan is followed."  If 4/27/23, at 6:50 p.m. are (LPN)-B indicated, R28 that up early in the morning and is but I haven't been able to a dated 1/23/23, indicated R28 at up between 6:00 and 7:00 p at 9:00 a.m., ate breakfast hen was not hungry for lunch. If actions taken included R28 overnight aide list of residents R28's preference to get up				
	Grievance summar	y dated 5/4/23, indicated R28				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00619	B. WING		05/1	; 1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	E MANOR LLC	640 THIRE				
(V 4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)NI	(Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	Continued From page	ge 67	21830			
	5:00 and 5:30 a.m., Summary of action	e to the dining room between and it was not happening. taken indicated DON added to R28 up on night shift and in und 6:00 a.m.				
	was to get out of be stated 3 out of 7 day	p.m., R28 stated preferance ed shortly after 6:00 a.m. R28 ys of the week he was not with morning cares and laid 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.					
		Quality of Life - Resident Self Participation dated 12/16,				
	Policy Interpretation	and Implementation				
	schedules and heal with his or her interests, values, as including: a. Daily routine, such eating, exercise and	allowed to choose activities, th care that are consistent seessments and plans of care, that as sleeping and waking, distanting schedules. Teds, such as bathing styles and dress.				
	2. In order to facilitate administration and s	ite resident choices, the staff:				

Minnesota Department of Health

	AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPI	SURVEY LETED	
		00619	B. WING		05/1	; 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BAYSIDI	E MANOR LLC	640 THIRE GAYLORE	O STREET O, MN 55334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT	.D BE	(X5) COMPLETE DATE
21830	the residents' right to participation in preference between the personal preference periodically thereafter, and document and conditions or limitate interfere with participation in preference of the director of nurse review and revise pensure residents we and bathing. The all staff to offer residents we and staff to offer residents we are supplied to the pensure residents are supplied to the pensure residents and the pensure residents are supplied to the pensure resident	ents and family members of to self-determination and erred activities. On about the residents' es on initial assessment and ument these preferences in on gathered about the tes in the care planning ommunicate any medical ions that may inhibit or	21830			