Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 15, 2024

Administrator
Bayside Manor, LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: February 7, 2024

Dear Administrator:

On February 28, 2024, we notified you a remedy was imposed. On March 27, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 14, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 14, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of February 28, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 14, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 14, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Your request for a 24-hour RN waiver has been approved based on the submitted documentation.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

February 28, 2024

Administrator
Bayside Manor, LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: February 7, 2024

Dear Administrator:

On February 7, 2024, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 6, 2024, the situation of immediate jeopardy to potential health and safety cited at F578 was removed. However, continued non-compliance remains at the lower scope and severity of J.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 14, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 14, 2024 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 14, 2024 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 14, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bayside Manor, LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 14, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 7, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	C 02/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/5/24 through 2/7/24 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		3/14/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/08/2024

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.

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E 037	Continued From page 1 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 2 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 3 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 4 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 staff (licensed practical nurse (LPN)-B, and registered nurse (RN)-B and RN-E), completed training in emergency preparedness policies and	E 037	E037 s/s F Submission of this Response and Plan of	

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E 037	Continued From page 5 procedures consistent with their expected role. This had the potential to affect all 30 residents in the facility. Findings include: During interview on 2/6/24 at 2:34 p.m., LPN-B indicated she was not aware of what her role as an LPN is for the emergency preparedness program specifically with during evacuations or sheltering in place. LPN-B indicated she has been at the facility for 3 years but has changed roles from nursing assistant to LPN since that time. LPN-B indicated she hasn't participated in any drills and doesn't remember having any education over the past year. During interview on 2/6/24 at 10:28 a.m., RN-B and RN-C indicated they were informed of where the emergency preparedness binder was located by other staff, but no further information was shared as to what their role in an emergency would be at this specific facility. RN-B indicated she had been here 6-7 times over the past six months. RN-C indicated she had not reviewed the facility emergency plan at this time and is not sure what her role is specific to this facility. On review of RN-B's Temporary Agency Staff Orientation Checklist, the Emergency Preparedness book location was not checked as part of her orientation, which was completed on 2/5/24. RN-B's Temporary Agency Staff Orientation Checklist was requested but was not received. Upon request from the administrator on 2/6/24 at 3:10 p.m., for annual training, she indicated there had not been any training that is documented	E 037	Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -LPN-B and RN-E will receive training on emergency preparedness policies and procedures as it relates to their expected role, prior to working their next shift. The process for satisfying this requirement has been reviewed and revised as needed to ensure that staff will be educated on their role for emergency preparedness. -All occupants of the facility have the potential to be affected if this requirement is not met.	

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E 037	Continued From page 6 over the past year. The administrator indicated they do have a plan to complete it in the next month.	E 037	-LPN-B and RN-E will receive education on emergency preparedness policies and procedures as it relates to their expected role prior to their next shift and annually thereafter. RN-B no longer works at the facility to complete education. Facility staff and agency still will receive education on emergency preparedness upon hire and annually. -Human Resources will complete audits of documentation to ensure required training was completed. Audits will be conducted weekly x4 and monthly x2. -The Maintenance Director or designee will provide training to new hires and annually on emergency preparedness policies and procedures. -Corrective action will be completed on or before 03/14/2024.	
E 039 SS=E	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises	E 039		3/14/24

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	245473	A. BUILDING _____ B. WING _____	C 02/07/2024

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BAYSIDE MANOR LLC	640 THIRD STREET GAYLORD, MN 55334

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E 039	Continued From page 7 to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct	E 039		

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E 039	Continued From page 8 exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual	E 039		

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E 039	Continued From page 9 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that	E 039		

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E 039	Continued From page 10 requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 11 based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next	E 039		

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E 039	Continued From page 12 required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 13 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 14 community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct	E 039		

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E 039	Continued From page 15 exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a full-scale community based exercise to test their emergency preparedness program (EPP) in response to an actual emergency event. This deficient practice had the potential to affect all 30 clients residing in the facility, along with staff who work in the facility. Findings include: Review of the facilities EPP revised on 9/7/23, lacked a community based exercise in the last year, to test their EPP. During interview on 2/7/24 at 3:32 p.m., the maintenance manager (MM), also identified as EPP coordinator, confirmed there had been no attempt made or community drill completed in the past year. MM indicated he just started about a year ago and had been in contact with the facilities coalition to participate in one over the next year.	E 039	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19	

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E 039	Continued From page 16 During interview on 2/7/24 at 4:10 p.m., the administrator indicated she believed the facility had participated in a full-scale community based drill. Information was requested. On 2/8/24 at 4:32 p.m., the administrator sent an electronic mail indicating she was not able to locate any documentation indicating the facility had participated in a full-scale community based drill.	E 039	programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed to ensure that a full-scale community-based exercise is completed to test the emergency preparedness program. -All occupants of the facility have the potential to be affected if this requirement is not met. -A full scale drill or exercise will be completed bi-annually. -Compliance will be reviewed quarterly at QAPI to ensure drills are done as required. -Communication has been initiated with community contacts to plan and schedule a full-scale community-based exercise or drill. -The Maintenance Director has been educated on full scale drill requirements. -The Maintenance Director or designee is responsible party. -Communication with community contacts for a full-scale drill or exercise has been initiated by 03/14/2024.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 17 On 2/5/24-2/7/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F578 when the facility failed to ensure an advance directives was accurately documented on the resident's electronic health record (EHR) banner and physician orders which affected 1 of 30 residents (R14) reviewed for advance directives. The IJ began on 1/31/24, and the immediacy was removed on 2/6/24. The following complaints were reviewed with NO deficiencies cited: H54739259C (MN00096574). The following complaints were reviewed: H54739370C (MN00095252) with a deficiency cited at F725. H54739371C (MN00095776) with a deficiency cited at F725. H54739372C (MN00096129) with a deficiency cited at F725. H54739246C (MN00096563) with a deficiency cited at F677. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

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F 550	Continued From page 18	F 550		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F 550		3/14/24

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F 550	Continued From page 19 reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents were provided care in a dignified and respectful manner for 1 of 2 residents (R17) who were observed during care interactions. Findings include R17's quarterly Minimum data Set (MDS) assessment dated 11/14/23, indicated R17 was rarely/never understood, no behaviors or rejection of care, utilized a walker, required substantial/maximal assistance with toileting, shower, dressing, personal hygiene, always incontinent of urine and bowel, and diagnoses included non-traumatic brain dysfunction, heart failure, non-Alzheimer's dementia, difficulty in walking, muscle weakness, and history of falling. R17's care plan dated 12/20/23, indicated functional bowel and bladder incontinence r/t (related to) dementia, always incontinent of bladder, frequently incontinent of bowel, assist with peri cares, toileting: extensive A1 (assist of one) upon rising, before and after meals, and at bedtime, check/change on NOC (night) rounds, the resident has limited physical mobility r/t Alzheimer's, dementia, heart failure, weakness, alteration in communication r/t Alzheimer's, e/b (evidenced by) mostly nonverbal, needs staff anticipation, needs will be anticipated and met by staff, use effective communication techniques: gain attention, do not startle, allow time to	F 550	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Based on observation, interview, and document review the facility failed to ensure residents were provided care in a dignified and respectful manner for 1 of 2 residents (R17) who were observed during care interactions. -R17□s care plan was reviewed and updated to include interventions for dignity and respect during toileting. -All residents of the facility have the potential to be affected by the same alleged deficient practice. -The facility has re-educated nursing staff on providing dignity and respect to our residents by providing privacy with closing the door during toileting and using appropriate terms to communicate with residents. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct	

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	245473	A. BUILDING _____ B. WING _____	C 02/07/2024

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F 550	Continued From page 20 respond, verify understanding. On 2/5/24 at 11:51 a.m., R17 used a walker and trained medication aide (TMA)-A walked next to R17 and walked into R17's room and then proceeded into R17's shared bathroom. The door to R17's room and bathroom door remained open. R17's roommate, R14, was seated in the room in her wheelchair and registered nurse (RN)-A walked into R17's room through the opened door and walked past the opened bathroom door while R17 was in the bathroom, and proceeded to administer insulin to R14. Overheard TMA-A while in the bathroom with R17, and stated, "go pee honey" and then heard the toilet flush. During an interview, TMA-A confirmed the door to the room or bathroom door was not shut while R17 used the toilet, and confirmed the door should have been shut to provide dignity to R17. During an interview on 2/7/24 at 11:22 a.m., the administrator stated she would expect the door to the room and bathroom shut when a resident was going to the bathroom and would expect residents communicated with in a dignified manner. The administrator stated the facility did not have a specific dignity policy but would follow the residents rights. The facility Resident Rights Policy dated 1/24, indicated: 4. The Combined Federal and State Bill of Rights will be posted in the facility in a location accessible to all residents. 5. Current copies of the Combined Federal and State Bill of Rights, in multiple languages, can be found at the following website: Patient, Resident	F 550	audits daily x5, Weekly x4, and monthly x2. Completion date: 3/14/2024	

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F 550	Continued From page 21 and Home Care Bill of Rights - MN Dept. of Health (state.mn.us) Combined Federal and State Bill of Rights For Residents In Medicare/Medicaid Certified Skilled Nursing Facilities Or Nursing Facilities dated 2/1/17, indicated: The resident has a right to a dignified existence, self- determination, and communication with and access to persons and services inside and outside the facility: 1. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. 2. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		3/14/24

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F 578	Continued From page 22 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an advance directives was accurately documented on the resident's electronic health record (EHR) banner and physician orders which affected 1 of 30 residents (R14) reviewed for advance directives. This resulted in an immediate jeopardy (IJ) for R14 who would have been denied cardiopulmonary	F 578	Plan of Correction—Code Status Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.	

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F 578	Continued From page 23 resuscitation (CPR) contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 1/31/24 when R14's Provider Orders for Life-Sustaining Treatment (POLST) identified R14 wished to have CPR administered, however, the physician orders in the EHR and EHR banner indicated R14 was do-not-resuscitate (DNR). The administrator was notified of the IJ on 2/5/24, at 8:03 p.m. The IJ was removed on 2/6/24 at 1:07 p.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R14's quarterly Minimum Data Set (MDS) assessment dated 1/5/24, indicated moderately impaired cognition, required assistance from staff with activities of daily living (ADL), and diagnoses of stroke, diabetes, non-Alzheimer's dementia, and anxiety disorder. On 2/5/24 at 2:30 p.m., R14's face sheet/banner in point click care (PCC) (computer program) indicated R14's code status was DNR. R14's most current Physician's Orders For Life Sustaining Treatment (POLST) located in the scanned EHR, signed by R14's family member (FM)-A on 1/25/24, and certified nurse practitioner (CNP)-A on 1/31/24, identified R14's wishes were full code status. R14's Order Summary report dated 1/30/24, indicated DNR status. The order summary failed to reflect the POLST of full code status signed by FM-A and CNP-A.	F 578	How corrective action will be taken for those affected by the alleged deficient practice: The facility has updated R14s code status to reflect the most up to date POLST. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has audited all residents and no other discrepancies have been found. The facility has completed a root cause analysis—and determined this code status was not updated as the HID did not update the order when she uploaded the document. · HID has been re-educated on the process · Nurses have been re-educated prior to the start of their next shift. The facility has added a review to their daily morning meeting to review any new POLST documentation and ensure new	

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F 578	Continued From page 24 During an interview on 2/5/24 at 2:35 p.m., registered nurse (RN)-A stated if a resident was found unresponsive and not breathing he would call the ambulance, then call the doctor, and would check the code status of the resident using the computer. Observed RN-A check the EHR stated R14 was DNR based on the code status reflected on the banner in PCC. RN-A confirmed he would not do CPR on R14. During an interview on 2/5/24 at 2:40 p.m., licensed practical nurse (LPN)-A stated the first placed she looked for code status (if a resident was found unresponsive) was the Kardex. LPN-A indicated the resident's Kardex was located inside the cupboard door of a resident's bathroom. Observed LPN-A open R14's bathroom cupboard door, inspected the Kardex, and confirmed the code status was missing from R14's Kardex. LPN-A stated she would then check the EHR and identified R14 had POLST completed recently and was a full code, and stated the banner on the EHR indicated DNR. LPN-A further stated she would do CPR because of the code discrepancy. During an interview on 2/5/24 at 2:45 p.m., RN-B stated R14's code status was DNR, and further stated she knew R14's code status because she worked with R14 last week. RN-B confirmed she would not implement CPR for R14. During an interview on 2/5/24 at 2:47 p.m., RN-C, also known as the regional nurse consultant, stated the first-place nurses should look to identify a resident's code status was on the EHR banner in PCC. RN-C further stated the health information coordinator (HIC), or the nurse was responsible for changing the order in the EHR	F 578	code statuses are updated. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct audits daily x5,Weekly x4, and monthly x2 and will report to the QA committee for further review and recommendations Completion date: 3/14/2024	

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F 578	Continued From page 25 based on POLST. RN-C verified R14's EHR banner of DNR would not have been correct because R14's POLST. signed by FM-A 1/24/24 and CNP-A on 1/31/24, indicated she's a full code. On 2/5/24 at 2:59 p.m., FM-A stated R14's wishes were to be full code. During an interview on 2/5/24 at 3:00 p.m., the HIC confirmed she was aware R14's code status had changed when she scanned the physician order dated 1/31/24, into the EHR and confirmed she should have updated the order at that time in the EHR from DNR to CPR for accuracy. During an interview on 2/5/24 at 3:35 p.m., the interim director of nursing (DON) stated if a resident's POLST was updated he expected the POLST scanned in the EHR, and the banner on the EHR changed when the order was scanned into the EHR. The DON stated typically the orders are processed within 24 hours, and the nurse was responsible ensure the orders were updated in the EHR accurately. The DON confirmed if staff don't follow this process/procedure resident wishes would not be followed. The facility Cardiopulmonary Resuscitation policy dated 11/19, indicated: The philosophy of Monarch Healthcare Management is to provide quality long and short-term caring and safe environment. Individual medical emergency response plans are developed for each resident based upon their individualized assessment, needs, preferences and advanced directives. A POLST form will be completed upon admission by the nurse manager or designee and reviewed	F 578		

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F 578	Continued From page 26 upon readmission, quarterly, and as needed (when there is a substantial change in the resident's health status; when the resident's treatment preferences change). A POLST form is a medical order, which means it us must be signed by a medical provider to be valid. When an emergency occurs, the nurse and/or clinical team will guide care provided, according to the resident and/or resident's representative identified preferences indicated on the physician's order within the plan of care. CPR will not be initiated if the resident has a valid DO NOT RESUSCITATE order in place OR he resident shows signs of irreversible death. The IJ was removed on 2/6/24, at 1:07 p.m., when the facility developed and implemented a systemic removal plan which was verified by interview and document review. On 2/5/24 at 3:30 p.m., the facility completed an audit of all resident's code status to ensure residents have matching code status order, POLST, and was reflected in the EHR, and the facility also completed a root cause analysis. The facility initiated training on 2/5/24 at 4:00 p.m., for all licensed nurses and HIC and were trained immediately or prior to their next scheduled shift regarding the updated POLST procedure and where to find a residents' code status. On 2/5/24 at 10:00 p.m., and on 2/6/24 at 6:00 a.m., oncoming licensed staff were educated regarding the updated POLST procedure and where to find a residents' code status. and continued for staff prior to their next shift. On 2/6/24 the facility reviewed the policy regarding code status and updated the policy, which outlined where the staff would locate the code status.	F 578		
F 623 SS=C	Notice Requirements Before Transfer/Discharge	F 623		3/14/24

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F 623	Continued From page 27 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		

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F 623	Continued From page 28 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 29 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure written notice of transfer was sent to the resident and/or resident representative for 2 of 2 residents (R15 and R16) reviewed for hospitalization. Findings include: R15's facesheet printed on 2/8/24, included a diagnosis of heart failure (when heart does not pump as well as it should). R15's quarterly Minimum Data Set (MDS) assessment dated 1/24/24, indicated R15 was cognitively intact, had clear speech, could understand and be understood. R15 required substantial/maximal staff assistance or was dependent upon staff for activities of daily living (ADL's).	F 623	How corrective action will be accomplished for those residents found to have been affected by the deficient practice¿ R16 has since been discharged from the facility and is not appropriate to provide written notice of transfer from 06/04/23 and 06/13/23 due to death. R15 was provided with written notice of transfer from 06/23/23 hospitalization. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur¿ All residents who have been hospitalized have the potential to be affected. Residents who have been hospitalized in the last 90 days were reviewed to ensure	

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F 623	Continued From page 30 R15's care plan with last review date of 1/1/24, included heart disease with heart failure. Staff were to monitor/document/report to MD (medical doctor) PRN (as needed) any signs or symptoms of altered cardiac output. During an interview on 2/5/24 at 2:49 p.m., R15 stated she had been hospitalized with congestive heart failure last summer. R15 stated she recalled signing a bed hold but did not recall signing and/or receiving a transfer notice. During record review, R15's document titled Bed-Hold Notice for Hospital Transfer and Therapeutic Leave, dated 6/13/23, did not indicate whether a copy of the completed form had been given to R15 and/or her representative. During record review, on 6/13/23, R15 had requested to go to the hospital due to chest congestion, cough and feeling weak. During record reviewed, R15 was transferred to the hospital via ambulance on 6/13/23 at 4:30 p.m. Nursing progress note indicated R15 signed a bed hold and R15's family member (FM)-H had been notified of R15's condition and request to go to the hospital. During record review, a progress note dated 6/14/23 at 1:20 p.m., indicated the hospital informed the facility R15 would be admitted for another day or two due to heart failure R16's facesheet printed on 2/8/24, included a diagnosis of COPD (chronic obstructive pulmonary disease). R16's significant change MDS assessment dated	F 623	written notice of transfer was provided to the resident and/or resident representative. Written notices identified to not have been appropriately provided were given to the resident or mailed to the resident representative. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur¿ Facility Bed Hold Notice and Hospital Transfer/Therapeutic Leave form was updated to include documentation that written notice was provided to resident and/or resident representative. Social Services, Health Information Manager, and Nursing staff were educated on the requirement to provide a written notice of transfer to resident and/or resident representative when resident is transferred to the hospital. Social Services or designee will ensure written notice was provided and mail copy to the resident representative if it had not been at the time of transfer. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Social Services Director or designee will conduct random audits to ensure written notice of transfer was sent to the resident and/or resident representative. Audits will be conducted weekly x 4, monthly x 2 and reported to QAPI committee for further review and recommendations.¿	

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F 623	Continued From page 31	F 623		

1/23/24, indicated R16 had severe cognitive impairment, clear speech, could understand and be understood. R16 required partial/moderate staff assistance or substantial assist with ADL's.

R16's care plan with last review date of 2/5/24, indicated COPD, metastatic (spreading) lung cancer, Alzheimer's disease, UTI's (urinary tract infections) and chronic Foley (catheter in bladder) and to keep the MD informed.

During an interview on 2/5/24 at 3:51 p.m., FM-G stated when R16 had been hospitalized some months ago, she did not recall signing a bed hold or receiving a copy of a transfer notice.

During record review, R16's document titled Bed-Hold Notice for Hospital Transfer and Therapeutic Leave, dated 6/4/23, did include notice of bed hold, but no indication the completed form had been given to R16 and/or his representative.

During record review, a progress note dated 6/4/2023, at 9:30 a.m., indicated R16 had been clammy, diaphoretic (sweating), coughing with drinks and meals, pale in color and complaining of excruciating left abdomen pain and back pain. The family had been notified and requested R16 be sent to a hospital.

During record review, a progress note dated 6/4/2023 at 11:38 a.m., indicated the hospital called the facility informing them R16 had been diagnosed with an UTI and pneumonia and would be admitted to the hospital.

During an interview on 2/7/24 at 2:16 p.m., licensed practical nurse (LPN)-C stated when a

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F 623	Continued From page 32 resident was transferred to the hospital, nursing staff obtained a form from a file drawer titled Bed-Hold Notice for Hospital Transfer and Therapeutic Leave, filled it out, had the resident sign it and placed it in a bin to be scanned into the record. LPN-C did not know what else was done with the form - whether a copy was given to the resident and/or resident representative. During an interview on 2/7/24 at 4:00 p.m., registered nurse (RN)-C also known as regional nurse consultant, reviewed R15 and R16's Bed-Hold Notice for Hospital Transfer and Therapeutic Leave form dated 6/13/23, and 6/4/23, respectively. RN-C stated the form was both a bed hold and a transfer notice form. RN-C acknowledged the form did not indicate if a copy of the form had been given to R15 and R16 and/or sent to R15 and R16's representatives. RN-C stated she thought the form had been updated to guide the process to ensure a copy of the transfer notice would be given to the resident and/or resident representative. In addition, RN-C had not been able to identify through documentation review, if the form had been given to R15 and R16, and/or their resident representative. During an interview on 2/7/24, at 5:20 p.m., the administrator stated the facility did not have a bed hold and/or transfer notice policy.	F 623		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		3/14/24

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F 677	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting, incontinence care and repositioning for 2 of 3 residents (R17 and R18) who were dependent upon staff for assistance with activities of daily living (ADL). Findings include: R17's quarterly Minimum data Set (MDS) assessment dated 11/14/23, indicated R17 was rarely/never understood, no behaviors or rejection of care, utilized a walker, required substantial/maximal assistance with toileting, shower, dressing, personal hygiene, always incontinent of urine and bowel, and diagnoses included non-traumatic brain dysfunction, heart failure, non-Alzheimer's dementia, difficulty in walking, muscle weakness, and history of falling. R17's care plan dated 12/20/23, indicated functional bowel and bladder incontinence r/t (related to) dementia, always incontinent of bladder, frequently incontinent of bowel, assist with peri cares, toileting: extensive A1 (assist of one) upon rising, before and after meals, and at bedtime, check/change on NOC (night) rounds, the resident has limited physical mobility r/t Alzheimer's, dementia, heart failure, weakness, alteration in communication r/t Alzheimer's, e/b (evidenced by) mostly nonverbal, needs staff anticipation, needs will be anticipated and met by staff, use effective communication techniques: gain attention, do not startle, allow time to respond, verify understanding R17's document staff referred to as the Kardex	F 677	R17 and R18□s care plan has been reviewed and updated related to toileting, incontinence care, and repositioning plans. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur¿ All residents dependent upon staff for assistance with activities of daily living have the potential to be affected. Dependent resident□s care plans were reviewed and updated related to toileting, incontinence care, and repositioning plans. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur¿ The facility has educated nursing staff on following the resident□s plan of care related to toileting, incontinence care, and repositioning. The facility will conduct random audits and review the results of them in the daily IDT meetings. The facility has identified the highest risk patients for adverse outcomes related to the alleged deficiency, and will prioritize them during audits. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur	

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F 677	Continued From page 34 dated 2/7/24, indicated toileting: extensive A1 (assist of one) upon rising, before and after meals, and at bedtime. Check/change on NOC (night) rounds. R17's document titled ADL dated 2/1/24-2/7/24, indicated R17's toilet use with one person extensive assistance : 2/7/24 at 2:23 a.m., 9:07 a.m., 4:01 p.m. 2/6/24 at 3:57 a.m. and 10:42 a.m., and 9:59 p.m., 2/5/24 at 12:44 a.m. and 10:48 a.m. 2/4/24 at 1:17 a.m., 9:59 a.m., and 9:59 p.m. 2/3/24 at 1:59 p.m. 2/2/24 at 12:29 a.m., 1:59 p.m., and 9:59 p.m. 2/1/24 at 2:55 a.m., 10:33 a.m., and 7:48 p.m. On 2/5/24 at 5:14 p.m., family member (FM)-F stated she routinely visits R17 at the facility and comes after 3:00 p.m., and stated she had to ask staff to bring R17 to the bathroom, and had not observed staff assist R1 to the toilet unless asked. FM-F stated when she visits the facility usually after 3:00 p.m., R17 was seated at the dining table or "slumped" in recliner in the day room. FM-F stated R17 was not able to ask for staff assistance and has found R17's brief wet with urine when seated in the recliner in the day room. During an observation on 2/6/24 from 12:58 p.m. - 4:48 p.m., R17 was observed seated in a chair in the common room, located near the nursing station (where two resident hallways meet, and adjacent to the dining room), and staff were observed to frequently walk by R17 as she sat in the chair. At 3:55 p.m., R17 continued to sit in the chair and was slumped down and leaned toward the left of the chair. At 4:46 p.m., R17 had slid	F 677	Director of Nursing or designee will conduct random audits of toileting, incontinence care, and repositioning to ensure it is occurring per each resident□s individualized care plan. Audits will be conducted daily x 5, weekly x2, monthly x2, and reported to QAPI committee for further review and recommendations.¿	

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F 677	Continued From page 35 further down in the chair and was in hunched body position. At 4:48 p.m., (3 hours later) R17 was assisted by RN-C and human resources director and repositioned in the chair to sit upright and continued to remain in the chair. On 2/6/24 at 5:13 p.m., R17 used a walker and nursing assistant (NA)-A and NA-C assisted R17 to the dining room table. NA-B and NA-C stated R17 was not toileted or offered toileting prior to evening the meal due to being busy with other resident cares and not enough staff. NA-A stated at 12:30 p.m., herself and NA-D assisted R17 with toileting and then assisted R17 to the common room to the chair she sat in during the day. NA-A stated R17 was expected to be toileted every two hours per the Kardex, NA-A confirmed R17 had not been toileted since 12:30 p.m., and was not offered to be toileted prior to be brought to the dining room On 2/7/24 at 7:01 a.m., NA-D stated yesterday (2/6/23), she assisted R17 to the toilet with the help of NA-A after lunch and then assisted R17 to the common area to sit in a chair. NA-D confirmed she did not toilet R17 the reminder of the day, and confirmed R17 was expected to be toileted every two-three hours. NA-D stated through charting or verbal report staff would know when a resident was toileted and further stated the toileting schedule was on R17's Kardex. On 2/7/24 at 8:51 a.m., NA-B stated after breakfast R17 was assisted to by staff and sat in the recliner in the common area and then assisted by staff to toilet prior to lunch. On 2/7/24 at 11:22 a.m., during an interview the administrator stated R17 required staff assistance	F 677		

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F 677	Continued From page 36 with toileting prior to her evening meal and expected staff assistance. The administrator stated R17 should not have sat in the common area on 2/6/24 from 12:30 p.m.-5:00 p.m., without staff toileting R17. The administrator stated staff were expected to follow the care plan. On 2/7/24 at 12:20 p.m., during an interview registered nurse (RN)-C, also known as the regional nurse consultant, stated a resident's toileting and incontinence cares were expected per the care plan. RN-C stated staff were expected to toilet R17 prior to meals and R17 was not expected to sit in the common room for the day without staff toileting R17. RN-C confirmed she repositioned R17 on 2/7/24, but did not toilet R17. R18's facesheet printed on 2/8/24, included diagnoses of dementia and morbid obesity. R18's quarterly MDS assessment dated 11/7/23, indicated R18 had severe cognitive impairment, clear speech, could understand and be understood. R18 required partial/moderate assistance with ADL's including toileting, repositioning walking and utilized a wheelchair. R18 was occasionally incontinent of urine and always continent of bowel. R18 did not have pressure ulcers. R18's physician orders included: --6/26/23, weekly skin assessment in forms section and ensure shower/bath is completed every evening shift every Friday. --12/27/23, Calzinc Cream (protects skin from chafing and irritation) to right and left buttock 2x/day as needed for MASD (moisture associated skin damage).	F 677		

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F 677	Continued From page 37 --1/30/24, wound care provider evaluation and treatment of sacral decubitus ulcer. --2/2/24, monitor placement of Mepilex on bilateral buttock every shift for pressure ulcer. R18's care plan dated 9/27/22, indicated R18 had alteration in skin integrity related to alteration in mobility, bowel, and bladder incontinence, re-current MASD to buttocks. Interventions included offloading (shift weight) and toileting at least every two hours; laid down on his side between meals. Staff to stand/offload resident frequently and lay on side when in bed to promote wound healing on bottom. R18's CAA (care area assessment) dated 5/4/23, indicated R18 had potential for alteration in skin integrity related to alteration in mobility, bowel and bladder incontinence and history of MASD. Provider wound care note dated 2/1/24, indicated R18 had been seen for wound care and evaluation of pressure ulcers with MASD to the right and left buttock. #1 Pressure Ulcer/MASD Buttocks Right 0.9 x 0.7 x 0. No exudate. 100% epithelial. #2 Pressure Ulcer/MASD Buttock left 1.5 x 1.5 No exudate. No odor. 100% epithelial. Both Stage 1 Pressure ulcer of right buttock, stage 1. Irritant contact dermatitis due friction or contact with other specified body fluids. Pressure ulcer of left buttock, stage 1. Irritant contact dermatitis due to fecal, urinary, or dual incontinence. Treatment recommendations: Cleanse, pat dry. Skin prep periwound. Apply Collagen powder to	F 677		

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F 677	Continued From page 38 wound bed. Cover with foam dressing. Change TID/PRN (three times a day and as needed). Offer/provide prompt peri care and offload. The provider note further indicated, per patient's plan of care: Offload and reposition frequently. During observations on 2/7/24, R18 had not been repositioned, offloaded or toileted for longer than three hours despite the care plan indicating he should be toileted and offloaded every two hours. 8:44 a.m., up in wheelchair at breakfast. 9:33 a.m., in wheelchair in front of TV in common room. 10:35 a.m., in wheelchair in chapel for church service. 10:51 a.m., returned to common area via wheelchair. 12:11 p.m., being toileted in his room per staff. During an interview on 2/7/24, at 12:26 p.m., NA-B stated she toileted R18 before lunch this day and didn't know if he needed to offload periodically as she was not taking care of R18 this day. During an interview on 2/7/24, at 1:22 p.m., (NA)-D stated she was responsible for R18's care and that R18 should be repositioned every two hours. NA-D stated she had not toileted, off-loaded or repositioned R18 since he left his room for breakfast. NA-D stated she felt like she didn't remember or didn't have time to reposition residents some days, but admitted it was important for R18's skin on his bottom so that it didn't breakdown. With R18's permission, NA-D took R18 to the tub room toilet to observe skin. R18 had a large piece of Mepilex (foam dressing) on both buttock; no pressure injury observed, but	F 677		

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F 677	Continued From page 39 some minor irritation such as pin point blood/redness noted. NA-D stated she was assigned to 11 residents by herself this day; six of whom needed mechanical lift transfers. NA-D stated it was a lot to do and remember. During an interview on 2/7/24 at 4:00 p.m., RN-C, who was also the regional nurse consultant, was informed of observations of R18 not being repositioned or toileted for greater than three hours, and staff responsible for R18's care admitted the same. RN-C stated she would agree, based on observations and interview with staff that R18 should have been toileted and repositioned every two hours. RN-C stated she would expect staff to adhere to R18's care plan. The facility 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. PROCEDURE: 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.	F 677		

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F 677	Continued From page 40 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		3/14/24

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F 688	Continued From page 41 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure staff provided a walking program to meet the assessed needs for 1 of 2 residents (R14) reviewed for restorative services. Findings include: R14's face sheet printed on 5/11/23, indicated diagnoses of cerebrovascular disease (conditions that impact the blood vessels in the brain) with dysarthria (speech disorder cause by paralysis or weakness of the muscles of the mouth) and hemiplegia and hemiparesis (paralysis), type 2 diabetes mellitus with neuropathy (nerve damage) and weakness. R14's quarterly Minimum Data Set (MDS) assessment dated 1/5/24, indicated moderate cognitive deficit, no behaviors, no rejection of care, utilized a walker and wheelchair, required substantial/maximal assistance with toileting, shower/bath, lower body dressing, dependent on staff for putting on/taking off footwear, set up with personal hygiene, partial/moderate assistance with upper body dressing, walking 10 feet, and walking 50 feet did not occur, diagnoses included stroke, non-Alzheimer's dementia, hemiplegia, and no restorative nursing program. R14's care plan dated 1/1/24, indicated limited physical mobility r/t (related/to) hemiplegia and hemiparesis right side, chronic pain syndrome,	F 688	How corrective action will be accomplished for those residents found to have been affected by the deficient practice¿ R14s walking program was re evaluated for appropriateness in resident's current condition and is currently on hold. R14 is being seen by PT/OT for weakness, difficulty in walking, unsteadiness of feet, and falls with no current recommendations for walking program. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur¿ The facility has reviewed all residents with a current walking program for appropriateness. Walking programs that were identified as no longer appropriate were re evaluated by therapy for updated recommendations. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur¿ The facility will educate staff on the importance of the walking programs and documenting refusals appropriately. The facility will audit completion of the walking programs weekly x4 and review the	

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F 688	Continued From page 42 low back pain, hx (history) falls, and weakness A1 (assist one) with getting legs in/out of bed and positioning; transfers: A1 with use of gait belt and walker, allow time to initiate on own and remind to stand tall. Encourage daily walking program with staff. R14's document staff referred to as the Kardex dated 11/14/23, indicated ambulation: contact guard min (minimum) A1 with use of gait belt, FWW (front wheeled walker) 2x/day (two times per day), remind to stand tall, stay close to walker, equal steps/assist with holding right hand on walker with second staff follow with wheelchair to tolerance (30-40') (feet). R14's progress note dated 2/7/24 at 2:12 p.m., registered nurse (RN)-D indicated obtained orders from NP (nurse practitioner) for PT (physical therapy) to eval and treat d/t (due to) increased weakness and declined in ambulation and transfers, transferring with A2 (assist two) at present ... walked resident with walker, with hand over her right hand to hang onto walker as well as guiding walker with w/c (wheelchair) to follow, R14 walked in hallway from her room to the next room, 20 feet with significant difficulty as she leaned to the right and using her good leg like it was her bad leg, dragging her right leg that is her affected side, also requested ROM program for UB (upper body) d/t right side hemiplegia, have ROM (range of motion) for LB (lower body) at present. Therapy Transfer Recommendations form dated 11/21/23, indicated R14 ambulation min assist, assist of two, wheelchair follow, gait belt, front wheeled walker 1x/day, reminded to stand tall and stay close to the walker, equal steps and	F 688	results of the audits with IDT. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The facility will audit compliance of the walking programs weekly x4, monthly x2 and quarterly x1. And review the results of the audits with the QAPI team.	

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F 688	Continued From page 43 assist with holding R (right) hand on walker with second staff member to assist with wheelchair follow, ambulate to tolerance in hallway (approximately 30-40') does better in morning, remind to go slow and hold gait belt with left hand assist with right hand walker, walking program. Physical Therapy Discharge Summary dated 11/30/23, indicated R14 discharge recommendations assist of one with FWW for transfers, walking program with caregivers; prognosis to maintain CLOF (current level of function) : good with consistent staff follow through. Review of point of care walking documentation dated 1/7/24 through 2/6/24, included: Walk in hallway: not applicable (NA): 75 times total dependence two person assist: 3 times one person extensive assistance: 1 time extensive assist two person: 1 time resident refused 2 times Walk in room: NA:73 times total dependence one person physical assist: 2 times extensive assistance one personal physical assist: 2 times total dependence two person physical assist: 3 times resident refuse: 3 times. On 2/5/24 at 11:49 a.m., R14 was seated in her wheelchair in her room and stated staff walked her once a week, and stated she required assistance with walking and would walk if staff offered. R14 stated she wanted to walk more and felt she was in the wheelchair too much. R14	F 688		

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F 688	Continued From page 44 added her back hurt because she sat in her wheelchair most of the day. On 2/5/24 at 12:05 p.m., R14's family member (FM)-D stated R14 was on a walking program, and stated R14 does not get assistance from staff to walk daily, and further stated she talked with PT last week about R14's good leg was not working as well as previously and has not received any information back from PT or nursing . On 2/6/24 at 1:46 p.m., R14 was in her wheelchair in her room. R14 stated no staff had walked her today, and stated the last time she walked was maybe last week, and stated she walks about once a week. On 2/7/24 at 8:45 a.m., licensed practical nurse (LPN)-B stated R14 was on a walking program and staff were expected to assist R14 with walking daily and stated there were not always enough staff at the facility to ensure residents were walked as expected. On 2/7/24 at 8:51 a.m., nursing assistant (NA)-B stated R14 walks sometimes,and other times not able to because R14 was too weak and confirmed staff were to chart in the computer when a resident was walked, and observed NA-B check the computer and stated R14's walking was taken off the computer as a task now, NA-B confirmed when she worked 2/5/24, R14 was expected to walk with staff. On 2/7/24 at 9:45 a.m., RN-D confirmed prior to 2/6/24, R14 was on a walking program and was expected to walk daily with staff. RN-D stated on 2/6/24, she updated the care plan and put the	F 688		

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F 688	Continued From page 45 walking program on hold and R14 would be revaluated by physical therapy (PT) due to staff stating the resident has had increased weakness. RN-D stated the walking program was on R14's Kardex and staff were expected to complete the walking program and chart in the EMR. RN-D stated she was currently acting as the nurse manager for the facility and was responsible to ensure residents were walked per PT's recommendations. On 2/7/24 at 1:10 p.m., RN-C, also known as the regional nurse consulted, confirmed R14 was expected to walk per PT discharge orders and stated staff were expected to discuss with nursing any concerns with a resident not being able to be walked and the Kardex and tasks were expected to be completed for residents. The facility 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. PROCEDURE: 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish	F 688		

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F 688	Continued From page 46 unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	How corrective action will be	3/14/24

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F 689	Continued From page 47 review, the facility failed to ensure care planned interventions to prevent falls were implemented for 1 of 3 residents (R13) reviewed for falls. Findings include: R13's quarterly Minimum Data Set (MDS) dated 1/11/24, identified R2 had moderate cognitive impairment, utilized a walker and wheelchair, required substantial/maximal assistance with toileting, shower/bathe, lower body dressing, sit to stand, required partial/moderate assistance with personal hygiene, walking, diagnoses included progressive neurological conditions, fracture, non-Alzheimer's dementia, Parkinson's disease, unsteadiness on feet, muscle weakness, indicated R13 had two falls with no injury and one fall with major injury since admission or prior assessment. R13's care plan dated 1/1/24, indicated at risk for falls related to alteration in mobility, Parkinson's, decreased safety awareness, bowel and bladder incontinence, and pain and interventions included assist to the bathroom at 2:00 p.m./2:30 p.m., call light anchored/affixed to rt (right) grab bar when in bed, to recliner when up for the day for easier access, check on resident around 7:00 a.m., and if awake get up for the day to decrease risk of attempting self transfer. Check on resident when in bed for proper body alignment to make sure resident is in the center of the bed, clothing bar at eye level to remind resident not to stand up, concave mattress on bed to reduce rolling out of bed, encourage resident to come out to the commons area and participate in activities in the afternoon, encourage resident to use reacher to pick items up off the floor, garbage can to be situated near resident when in bed and recliner.	F 689	accomplished for those residents found to have been affected by the deficient practice¿ R13□s fall interventions were reviewed for appropriateness on 02/06/24. Care plan was updated to reflect resident□s refusal of reminder signs and Dycem in room and behavior of removing these items. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur¿ All residents assessed to be at risk for falls and with fall interventions in place have the potential to be affected. All residents with current care planned fall interventions were reviewed to ensure interventions to prevent falls were implemented. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur¿ Staff were educated on notifying nursing leadership for further assessment if residents are known to be refusing care planned fall interventions. Nursing leadership were educated on facility Incident Review and Analysis process to include review of current fall interventions in place for continued appropriateness. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur	

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F 689	Continued From page 48 Know that it is possible that resident may self transfer and/or move the garbage can on her own as she is noted to be impulsive at times, grip socks on when in bed, grip socks or shoes on when up, if door is closed, knock on PRN (as needed) and check on her, night shift to do 1st priority check as soon as they get here and offer toileting and assist into bed if she is not already in bed. Non-skid strips added to the bedside floor. Non-skid strips applied to floor in front of closet. Offer to assist resident to the bathroom at 1900 (7 p.m.), Place pillow at exit side of bed to remind resident where edge of bed is. PT/OT (physical therapy/occupational therapy) to eval and treat r/t recurrent falls, replace signs in room to remind resident to use call light and wait for assistance. reminder signs in room to remind resident to turn on call light and wait for help, replace old Dycem (non-slip material) in recliner with new Dycem. W/C (wheelchair) to be next to bed or recliner, floor mat next to bed. R13's Kardex dated 2/7/24 indicated, check on resident around 7:00 a.m., and if awake getup for the day to decrease risk of attempting self transfer, check on resident when in bed for proper body alignment to make sure resident is in the center of the bed, concave mattress on bed to reduce rolling out of bed encourage resident to come out to the commons area and participate in activities in the afternoon. Encourage resident to use reacher to pick items up off the floor, floor mat next to bed. Garbage can to be situated near resident when in bed and recliner. Know that it is possible that resident may self transfer and/or move the garbage can on her own as she is noted to be impulsive at times. Grip socks on when in bed. Grip socks or shoes on when up IF door is closed, knock on PRN and check on her.	F 689	Director of Nursing or designee will conduct random audits to ensure care planned fall interventions to prevent falls are implemented. Audits will be conducted weekly x 4, monthly x 2 and reported to QAPI committee for further review and recommendations.¿	

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F 689	Continued From page 49 Night shift to do 1st priority check as soon as they get here and offer toileting and assist into bed if she is not already in bed. Non-skid strips added to the bedside floor. Non-skid strips applied to floor in front of closet. place concave mattress on bed. Place pillow at exit side of bed to remind resident where edge of bed is, reminder signs in room to remind resident to turn on call light and wait for help. Replace old Dycem in recliner with new Dycem. W/C to be next to bed or recliner R13's incident review and analysis dated 1/25/24, indicated on 1/25/24 at 9:55 a.m., R13 was found on the floor and was rummaging through the items on her table, and did not have socks or shoes on, alert to person, place, cognitive status declining, possible interventions included place items within resident reach, and grip socks or shoes on at all times, staff education and interventions care planned. R13's incident review and analysis dated 12/8/23, indicated on 12/8/23 at 3:28 p.m., R13 was found on floor and front of her recliner. Stated she was attempting to self transfer from her recliner to the w/c to go to the bathroom and lost her balance. Resident did not use call light to call for staff assist, current interventions indicated see care plan, and intervention added assist resident to the bathroom at 2:00-2:30 p.m. On 2/6/24 at 1:11 p.m., R13 was seated in a recliner in her room stated she falls frequently and fell about one month ago. R13 stated sometimes she has too wait too long for staff to come help her and gets to the point she can not wait to use the bathroom, and then transfers herself. R13 room was observed; and there were no visible signs posted in her room to remind	F 689		

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F 689	Continued From page 50 resident to use call light and wait for assistance as directed per R13's care plan and Kardex. On 2/6/24 at 3:00 p.m., R13 was seated in her recliner, with shoes on her feet, and no signs to turn on call light and wait for help were visible in R13's room. On 2/6/24 at 3:22 p.m. during an observation of R13's room with registered nurse (RN)-D. RN-D confirmed there were no signs posted to remind R13 to turn on call light and wait for help and confirmed no Dycem was in recliner or wheelchair for R13. RN-D was observed to look throughout R13's room for a Dycem and was unable to locate. RN-D confirmed a Dycem was expected in R13's wheelchair and recliner. RN-D stated replaced the Dycem in the past and stated R13 is known to transfer without waiting for staff assistance or using her call light. RN-D stated not following the R13's fall interventions of signs posted and Dycem was a potential fall risk and stated the point of the fall interventions was to prevent the falls. On 2/6/24 3:28 p.m., RN-C, also known as the regional nurse consultant, stated she would expect interventions followed and implemented per R13's care plan. RN-C stated she was informed by administrator R13 was known to remove the signs posted in her room asking for help. RN-C confirmed fall interventions should be modified if R13 was known to remove the signs that were put in place to prevent falls. On 2/7/24 at 7:19 a.m., nursing assistant (NA)-E stated she was not aware R13 had a Dycem or had an intervention for signs posted in her room that indicated R13 should use call light and wait	F 689		

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F 689	Continued From page 51 for assistance. NA-E stated R13 was known to pull things off her wall. On 2/7/24 at 8:47 a.m., licensed practical nurse (LPN)-B stated R13 was a fall risk and stated R13 was known to self-transfer and stated interventions included wearing grippy socks and shoes, fall mat, and fall signs should be posted in her room. LPN-B stated a Dycem in R13's wheelchair or recliner was not an intervention. On 2/7/24 at 8:49 a.m., R13 was observed in her recliner and no signs to wait for assistance or use call light were observed posted in R13's room. The facility Fall Prevention and Management policy dated 9/23, indicated The purpose of this protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Managing Falls and Fall Risk Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the nature of or type of fall, until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious	F 689		

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F 689	Continued From page 52 consequences of falling. Staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. Implement interventions, including adequate supervision and assist devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		3/14/24

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F 725	Continued From page 53 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide sufficient staffing to ensure residents received care and assistance as needed and requested. These deficient practices had the potential to affect all 30 residents who resided in the facility. Findings include: Refer to F677: Based on observation, interview and document review, the facility failed to provide timely toileting, incontinence care and repositioning for 2 of 3 residents (R17 and R18) who were dependent upon staff for assistance with activities of daily living (ADL). Refer to F688: Based on interview, observation and document review, the facility failed to ensure staff provided walking program to meet the assessed needs for 1 of 2 residents (R14) reviewed for restorative services. Refer to F689: Based on observation, interview and document review, the facility failed to ensure assessed and care planned interventions to prevent falls were implemented for 1 of 3 residents (R13) reviewed for falls. MDS:	F 725	Plan of Correction—F725 Sufficient Nursing Staff Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. -The process for satisfying this requirement has been reviewed and revised, to ensure the facility has sufficient staffing. -All residents dependent upon staff for assistance with activities of daily living have the potential to be affected. -The facility has re-educated nursing staff on the importance of providing walking programs. The facility has educated nursing staff on following the residents plan of care related to toileting, incontinence care, and repositioning. Staff were educated on notifying nursing leadership for further assessment if residents are known to be refusing care planned fall interventions. Nursing leadership were educated on facility	

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F 725	Continued From page 54 R6's significant change Minimum Data Set (MDS) assessment dated 12/29/23, indicated severe cognitive impairment, no rejection of care, at risk for development of pressure ulcers, no unhealed pressure ulcers, no turning and repositioning program. R6 was dependent upon staff for most activities of daily living (ADL's) including repositioning. R8's quarterly MDS assessment dated 11/22/23, identified R8 had moderate cognitive impairment, no behaviors or rejection of care, required partial/moderate assistance with toileting, shower/bathe, lower body dressing, personal hygiene, and was dependent on staff for toilet transfer, and used a wheelchair for mobility. R9's quarterly MDS assessment dated 1/4/24, indicated R9 was cognitively intact, no behaviors or rejection of care, dependent on staff for shower/bathe, lower body dressing, required partial/moderate assistance with personal hygiene, and used a wheelchair for mobility. R11's quarterly MDS assessment dated 11/9/23, indicated R11 was cognitively intact, no behaviors or rejection of care, required substantial/maximal assistance with personal hygiene, upper body dressing, shower/bathe, dependent on staff for lower body dressing and transfers, and used a wheelchair for mobility. R12's significant change in status MDS assessment dated 12/2/23, indicated R12 required supervision with toileting, hygiene, shower/bathe, personal hygiene, independent wit sit to stand, toilet transfer, chair/bed transfer, and used a wheelchair for mobility.	F 725	Incident Review and Analysis process to include review of current fall interventions in place for continued appropriateness. -Facility will reeducate staff on answering call lights and resident Kardex. Facility will review schedule daily in morning meeting to ensure appropriate staffing. Facility will review call light times in morning meeting. -DON or Designee will conduct audits weekly x 4, monthly x 2. Completion date: 3/14/2024	

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R14's quarterly MDS assessment dated 1/5/24, indicated R14 had a moderate cognitive deficit, no behaviors, no rejection of care, utilized a walker and wheelchair, required substantial/maximal assistance with toileting, shower/bath, lower body dressing, dependent on staff for putting on/taking off footwear, set up with personal hygiene, partial/moderate assistance with upper body dressing.

R15's quarterly MDS assessment dated 1/24/24, indicated R15 was cognitively intact, had clear speech, could understand and be understood. R15 required substantial/maximal staff assistance or was dependent upon staff for activities of daily living (ADL's).

R16's significant change MDS dated 1/23/24, indicated R16 had severe cognitive impairment, clear speech, could understand and be understood. R16 required partial/moderate staff assistance or substantial assist with ADL's.

R17's quarterly MDS assessment dated 11/14/23, indicated R17 was rarely/never understood, no behaviors or rejection of care, utilized a walker, required substantial/maximal assistance with toileting, shower, dressing, personal hygiene, always incontinent of urine and bowel, and diagnoses included non-traumatic brain dysfunction, heart failure, non-Alzheimer's dementia, difficulty in walking, muscle weakness, and history of falling.

R18's quarterly MDS assessment dated 11/7/23, indicated R18 had severe cognitive impairment, clear speech, could understand and be understood. R18 required partial/moderate assistance with ADL's including toileting and

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F 725	Continued From page 56	F 725		

repositioning. R18 was occasionally incontinent of urine and always continent of bowel. R18 used a wheelchair for mobility.

R20's quarterly MDS assessment dated 10/30/23, indicated R20 was cognitively intact and was dependent on staff for toileting, shower/bath, lower body dressing and personal hygiene, toilet transfer, chair to bed transfer, and used a wheelchair for mobility.

R23's quarterly MDS assessment dated 2/1/24, indicated R20 required substantial/maximal assistance with shower/bathe, dressing, and personal hygiene, and used a wheelchair for mobility.

Resident and Family Interviews:

On 2/5/24 at 11:08 a.m., R23 stated it was not uncommon for him to wait for up to one hour for staff assistance to provide cares.

On 2/5/24 at 11:48 a.m., R9 stated the shortest amount of time her call light was answered was 20 minutes and had to wait up to an hour.

On 2/5/24 at 12:15 p.m., family member (FM)-E stated the facility did not have enough staff on the evening shift, and stated the staff on the evening shift were consistently agency staff who were unfamiliar with R14's cares and routines, and caused R14 delayed assitance for bedtime.

On 2/5/24 at 12:30 p.m., R8 stated the facility did not have enough staff on the evening shift and consistently takes staff 30 minutes to answer her call light. R8 stated at times she waits up to an hour and half for staff to respond to her call light

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F 725	Continued From page 57 when she is requesting help to go to bed. On 2/5/24 at 1:34 p.m., R20's FM-I stated staff answered the call light between five minutes and 45 minutes. FM-I stated the number of agency staff impact R20's care, due to not knowing his plan of care and not trained for his routines. On 2/5/24 at 2:18 p.m., R12 stated he waited 15-30 minutes for staff to answer the call light, and further stated he took himself to the bathroom. On 2/5/24 at 2:26 p.m., R15 stated staff answered call lights anywhere from five minutes to one hour. R15 further discussed an incident in August 2023, when she was put on a bedpan and left for more than an hour. R15 stated an unidentified nursing assistant (NA) stated she would tell the oncoming NA she was on the bedpan, but no one found her until another staff came into her room. R15 stated her call light was on the whole time. On 2/5/24 at 3:38 p.m., FM-G stated the facility was understaffed and that required R16 to have to sit in his wheelchair too long after supper. FM-G further stated there was not enough staff and waited too long for staff assistance to put R16 to bed. FM-G stated at times R16 waited 30 minutes to an hour for staff to respond to his call light. On 2/5/247 at 5:14 p.m., during a phone interview FM-F stated she routinely visited the facility after 3:00 p.m., and stated R17 was usually still seated at the dining room table or "slumped" in a chair in the common room. FM-F stated on one incident when she visited the facility at 3:30 p.m., R17 was	F 725		

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F 725	Continued From page 58 seated at the dining table by herself and staff stated R17 had been at dining table since 11:30 a.m. FM-F stated other times she visited the facility she had to ask staff to toilet R17, was frequently found "slumped" in recliner in the common room and her brief wet with urine. FM-F stated she had voiced her concerns to the social worker and had not seen any improvement in care. FM-F stated R17 was not able to voice to staff when she needed assistance and stated she expected R17 toileted and not in a wet brief. During a follow up interview on 2/7/24 at 5:08 p.m., FM-F stated on 12/7/23, when visiting R17 she put R17's room call light on to get assistance and after 35 minutes went out to the hallway to get help from staff to toilet R17. FM-F located a staff member in the hallway and asked the staff working if it always took this long to answer call lights and the staff stated she was not sure as it was her first time working at the facility. FM-F further stated when she came to the facility today (2/7/24), she found R17 in her room in bed and was surprised she was not slumped in the chair in the common room. On 2/7/24 at 2:17 p.m., during resident council meeting, R8, R11, R14, R15, and R18 voiced concerns and voiced agreement regarding staffing concerns of the facility and long wait times for call lights to be answered. R8, R11, R14, R15, R18 further stated delay in receiving staff assistance with going to bed, and stated there was mainly agency staff that usually worked in the evenings and they were not familiar with the care needed. Further, staff did not routinely use the care plan that was provided in the cupboards in the bedroom or bathroom that directed their care. R11 stated when staff were	F 725		

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F 725	Continued From page 59 not familiar with her care she was able to tell staff what to do. R11 further stated she was not sure how staff were caring for residents who could not communicate their needs. R15 and R11 stated staff will enter the room shut the call light off, exit the room and did not assist them, and further discussed they would put the call light back on again, because staff did not provide the assistance when the call light was shut off. R15 stated within the last six months there was an incident where staff left her on the bedpan for over 2 ½ hours. Staff Interviews: On 2/5/24 at 12:05 p.m., NA-D stated the facility consistently utilized agency nursing for the evening shift for several months, and staff from the day shift were required to stay for the evening shift. NA-D stated she consistently worked the evening shift two to three times a week because the evening shift was short staffed. NA-D discussed the evening staff had been short for several months, and at least six months. NA-D stated the day and overnight shift was staffed with facility staff who were familiar with resident cares, and the evening shift used agency staff who come one hour before the shift to orientate, and stated there was not consistent evening staff to follow up resident cares, complete timely bedtime routines, and answer call lights timely. NA-D stated the inconsistent staff on the evening shift caused a delay in answering call lights, delayed meals, and missed baths, due to staff not familiar with resident routines and interventions. On 2/6/24 at 10:28 a.m., registered nurse (RN)-B and RN-E stated they were agency nurses at the facility. RN-E stated she was the only nurse until	F 725		

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F 725	Continued From page 60 9:30 a.m., when RN-B came for her shift. RN-B stated she was late for her shift because she worked until 10:30 p.m., last night. RN-B and RN-E stated when there was one nurse and one TMA for the scheduled shift there was not enough skilled nursing staff to complete cares and get resident treatments completed timely. RN-E stated the current census was 30 and that it was "overwhelming" as the only nurse. RN-B and RN-E stated resident cares and treatments were a lot responsibility for one nurse, and overwhelming when there was a not facility nursing staff available to assist. On 2/6/24 at 11:54 a.m., NA-A stated at times there were only two NA's for the evening shift, and then a NA from the day shift would be required to stay for the evening shift. NA-A stated many of the residents at the facility required extensive assistance from staff and many of the residents were assist of two that caused delays in the resident evening cares, unable to take the time needed to care for residents properly, and a delay in answering call lights. On 2/6/24 at 12:14 p.m., social services (SS)-A stated a new process started about three months ago and the call light logs were ran after each shift by the nurse, and the staff working that shift were expected to assess the call light times and stated if the nursing staff feel that was longer then expected call light time staff were expected to hand write an explanation next to the time on the paper call light log audit. SS-A stated daily she looked over the call light logs, data, and explanation if any for why there was a long call light, and the information is shared during the day stand up meeting with management. SS-A stated the trend at the facility with higher call light times	F 725		

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F 725	Continued From page 61 was on the evening shift, in morning, and when residents wanted to go to bed. SS-A stated education was given routinely to all staff that nurses can answer call light, use walkie talkies, and continued daily reminders. SS-A confirmed long call light at the facility, and stated there would be days there would not be delay in call lights and then would see a trend in longer call lights again. SS-A stated the nurse manger RN-D, RN-C, director of nursing (DON) were responsible for educating staff. During the interview the call light log audits were reviewed for the past 30 days with SS-A and confirmed long call times for residents, and stated it had been improvement from several months ago. On 2/6/24 at 2:34 p.m., licensed practical nurse (LPN)-B stated she was pulled to work as a NA today today as the facility did not need her as a nurse. LPN-B stated the facility had four NA's today, however there was usually only two-three NA's on the day and evening shift. LPN-A stated consistently staff called in and did not come in for their shift, and for several months the facility had relied on agency staff to fill the schedule. LPN-A stated the short staffing and unfamiliarity with the resident care led to a delay in answering resident call lights. LPN-A stated some staff struggled to know the residents routine and care required to ensure residents ADL's were completed and completed timely, which caused missed baths, call light delays, residents not going to bed at the time they want. LPN-A stated specific concerns when residents require two staff assist with mechanical lifts and there are only two or three staff working to assist residents. On 2/7/24 at 7:21 a.m. NA-E stated the evening staffing schedule was consistently not filled and	F 725		

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F 725	Continued From page 62 staff on a routine basis had to work a double shift. NA-E stated the night shift consisted of one NA and one nurse and residents that required assist of two, would need to wait and for the NA and the nurse to be available at the same time to assist residents. NA-E stated resident care was not always performed per the Kardex, delay with transfers and delay with call lights answered due to staff not consistently carrying a walkie talkie, openings in the evening schedule, increased agency staff on evening shift and not having the knowledge of the specific resident care. On 2/7/24 at 8:02 a.m., the administrator stated the facility's expectation for staff to respond to call lights was within 20 minutes, and stated the longer call light times on some of the call light logs were due to residents requesting the call light be left on. The administrator stated she was not sure why the residents requested to have their call light left on and confirmed residents had not been asked about the reasoning. The administer stated she did not see a concern with not having enough staff and stated the long call light times were due to resident requesting to leave their call lights on. The administrator stated if there were excessively long call light response times, the facility looked at what was going on at the time,if there had been many lights going off at the same time, that increased the wait time for other residents. The administrator did not correlate long call light times with the number of staff on duty. During a follow up interview on 2/7/24 at 10:20 a.m., the administrator stated the facility was staffed according to census and case mix. The adminstartor stated the long call light times identified on the call light log audits were	F 725		

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F 725	Continued From page 63 expected to have a reason behind the time, and was a concern if staff were not addressing the long call light times. The administrator stated the facility had not identified trends due to agency staff not answering call lights timely. The administrator stated she was aware that the nurse and NA might go on break at the same time and could cause less staff on the floor at the time to assist residents. The administrator stated agency staff came in an hour before their shift and completed an orientation checklist with another NA or nurse. The administrator stated she has made observations of staff going into the rooms to assist residents and the call lights not shut off by staff that could indicate longer call light times. The administrator stated the star system was implemented to help with staffing holes and call ins. The administrator stated if a staff has a star by their name and there was a hole in the schedule or a call in, the staff member with a star by their name stayed for the next shift, ideally would only be four hours, but at times staff worked an additional eight hour shift. The administrator stated the facility was currently accepting admissions, however ensured the residents were not complex. The administrator stated the facility currently had one day and evening nurse that was not agency; six open nurse positions, and eight open NA positions. The administrator stated the facility had been trying to recruit staff and have had difficulty in retaining staff and hiring staff. The administrator stated she was not aware resident needs were not consistently met. She further indicated the facility continued to work on achieving and maintaining staffing levels. During an interview on 2/7/24 at 1:22 p.m., NA-D stated she felt like she didn't remember or didn't	F 725		

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F 725	Continued From page 64 have time to reposition residents some days, but admitted it was important. NA-D stated she was assigned to 11 residents by herself this day; six of whom needed mechanical lift transfers. NA-D stated it was a lot to do and remember. On 2/7/24 at 3:14 p.m.,during an interview with human resources director (HR)-D stated the facility had multiple open NA and skilled nursing positions, and further stated finding licensed staff was difficult as they are non-existent. Staffing schedules: Review of the facility's staffing schedules for 2/7/24 through 1/8/24. The schedules lacked required nursing assistants for the following: 1/22/4: 4 hours on the evening shift 1/14/24: one NA on day shift 1/13/24: one NA on day shift 1/10/24 one NA on day shift 1/9/24: 4 hours on the evening shift 1/8/24: 4.5 hours on the evening shift Grievance Reports dated 5/20/23-1/22/24: 22 grievance reports related to staffing concerns and timeliness of staff. Grievance summaries indicated: 8/11/23, R15 reported "Saturday was a bear"...put on the bedpan at 6:30 p.m. and didn't take be off until 9:00 p.m., staff came in to assist roommate and did not take R15 off bedpan. Summary of findings indicated call light on for extended period of time, staff education and corrective action as necessary. 10/23/23, FM-F reported R17 still in dining room	F 725		

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F 725	Continued From page 65 eating lunch at 3:10 p.m., when FM-F arrived. Summary of investigation indicated R17 was often in the dining room for an extended period of time. Actions taken indicated staff to help assist to dining room at beginning of mealtime to provide long time to eat, aides to toilet once meal are finished, staff to allow R17 to eat for 1 to 1 1/2 hours. 9/13/23, FM reported R20 was not getting up in a timely manner in the morning and then gets to breakfast at 10:00 a.m. and at noon meal, FM reports R20 is not removed from table in timely manner. Summary of actions taken new sunrise shift has been established to give more support to the morning shift so there will be 4 NA's in the morning to assist with getting residents up per preferences, staff to continue to assist residents with their preferences as able. 10/9/23, FM reported R6 wasn't put to bed until 10:51 p.m. on 10/9/23. Summary of investigation indicated a number of outside agency staff were working on 10/9, and didn't realize R6's bedtime preferences, summary of actions taken indicated order added to ensure R6 was assisted to be per her time preference. 12/13/23, R6 FM reported R6 had not been toileted in a timely manner. Summary of investigation indicated R6 was not toileted according to care plan, actions taken indicated DON verbally educated staff to follow residents plan of care. Call light logs: Review of the call light response logs, provided by the facility revealed numerous occasions of	F 725		

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longer than 20 minutes wait times. The following were examples of the long wait times. These included but were not limited to the following:

1/8/24-2/6/24, R17: longest wait times were 37 minutes, 27 minutes

1/6/24-2/6/24, indicated room R20's longest wait times were longest wait times were 2 hours and 22 minutes, 32 minutes, 24 minutes 1 hour and 4 minutes, 28 minutes, 47 minutes, 1 hour and 47 minutes, 48 minutes, 33 minutes, 46 minutes, 33 minutes, 23 minutes, 1 hour and 14 minutes, 47 minutes, 33 minutes, 23 minutes, 25 minutes, 43 minutes, 52 minutes, 28 minutes, 39 minutes, 31 minutes, 34 minutes.

1/7/24-2/6/24, indicated R8's longest wait times 22 minutes, 33 minutes, 39 minutes, 29 minutes, 28 minutes, 32 minutes, 37 minutes, 23 minutes.

1/6/24-2/6/24, indicated R25's longest wait times 29 minutes, 26 minutes, 22 minutes, 37 minutes, 43 minutes, 27 minutes, 42 minutes, 27 minutes, 35 minutes, 24 minutes, 33 minutes, 25 minutes, 39 minutes.

1/6/24-2/6/24, indicated R9's longest wait times 45 minutes, 59 minutes, 23 minutes, 33 minutes, 23 minutes, 1 hour and 22 minutes, 35 minutes, 59 minutes, 42 minutes, 27 minutes.

1/6/24-2/6/24, indicated R22 longest wait times 23 minutes, 29 minutes, 55 minutes, 33 minutes.

1/6/24-2/6/24, indicated R16's longest wait times 33 minutes, 22 minutes, 23 minutes, 37 minutes, 34 minutes, 21 minutes, 37 minutes, 29 minutes, 50 minutes, 25 minutes, 52 minutes, 1 hour 45

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

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F 725	Continued From page 67 minutes. 1/6/24-2/6/24, indicated R23's longest wait times 33 minutes, 22 minutes, 1 hour and 34 minutes, 26 minutes, 29 minutes, 36 minutes, 34 minutes, 27 minutes, 30 minutes. 1/6/24-2/6/24, indicated R15's longest wait times 32 minutes, 39 minutes, 22 minutes, 32 minutes 54 minutes, 33 minutes, 29 minutes, 26 minutes, 1 hour and 24 minutes, 55 minutes, 26 minutes, 35 minutes, 27 minutes, 37 minutes, 38 minutes, 48 minutes, 39 minutes, 1 hour, 40 minutes. 1/6/24-2/6/24, indicated R12's longest wait times: one hour and 13 minutes, 25 minutes, 27 minutes, 38 minutes, 22 minutes, 54 minutes, 41 minutes, 35 minutes Facility call log audits dated 12/31/23-2/5/24, (that nursing completed after each shift), indicated 142 times call lights were marked and hand written notes indicated: Two staff on break : 15 times Awaiting second assist 10 times Staff doing shower 3 times Waiting for female 11 times Resident did not know 1 times Refused call light off 3 times All aides feeding 1 time Staff forgot to shout off light 5 times Staff in room 4 times Awaiting bed 22 times No reason indicated 67 times Call light printout dated 1/18/24 at 2:15 p.m. handwritten note indicated short staffed. A policy regarding staffing was requested and the administrator stated the facility did not have a	F 725		

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F 725	Continued From page 68 policy specific to staffing. The Facility Assessment dated 11/8/23, indicated Part 1: Our Resident Profile Numbers 1.1. The number of residents we are licensed to provide care for: 42 1.2. Average daily census for the overall facility is 28-33. Short Term Care averages a daily census of 0 - 5 residents. Long Term Care Averages a daily census of 28 - 33 residents. 1.2.a. The number of persons admitted and discharged on a bi-weekly basis are listed on the chart below. Our staffing levels are reviewed daily to determine if additional staff are needed to support the change in census. Other 7. Other Factors that impact staffing. On an ongoing daily basis, the scheduler, Director of Nursing and other key interdepartmental team members review staffing levels based upon our current resident population, acuity, and resident specific needs. (e.g., residents ' preferences with regard to daily schedules, morning and evening ADLs, bathing, activities, naps, meal & snack times, 1:1 ' s, etc.) Staffing plan 3.2. Staffing is reviewed daily by the Scheduler, Director of Nursing, and Administrator to ensure that the staffing level supports our resident centered care needs. A copy of the staffing ratio is posted on the Facility Community Communication Board located in the hallway by the main dining room. This board is in a conspicuous location, visible to all staff, residents,	F 725		

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F 725	Continued From page 69	F 725		

and visitors.
Table 1 demonstrates our average daily staffing based on our average census and resident acuity. The staffing level represents the staff in all units within the Gardens at Foley. (View an example Nursing Staff Ratio Matrix in Appendices II.)

Position	AM	PM	NOC
RN Nursing Leadership	1-2	0	0
Licensed nurses providing direct care	1-2	1-2	1
Nurse aides	2-3	2-3	1-2
TMA	0-1	0-1	0

Individual staff assignment
3.3. Staffing is reviewed daily by the Scheduler, Director of Nursing, and Administrator to ensure that the staffing level supports our resident centered care needs. When looking at staffing levels, the team also reviews staff performance and compatibility within the assigned unit, then adjustments are made accordingly. Staffing challenges are reported each weekday at IDT meetings, weekends, and as needed to DON and/or Administrator outside of normal business hours.
Resident ' s continuity of care is completed by having consistency in our staff schedules by assigning them to the same unit as frequently as permitted. This provides consistency and familiarity for the residents and staff on daily routines, preferences and builds entrusting relationships. Though, resident safety is priority and this may not be realistic each day.

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F 725	Continued From page 70 Staff training/education and competencies 3.4. Bayside Manor, in accordance with Monarch Healthcare Management policy and procedure requires Licensed and certified staff to provide proof of licensure/certification during the application process. Holding a current license/certification relevant to their position is a condition of hire. Once the offer has been extended, the Human Resources department verifies the required licensure/certifications are valid. Licensed staff include but are not limited to: Administrator, Registered Nurse, Licensed Practical Nurse, Social Services Director, and Health Unit Coordinator Certified Staff include but are not limited to: Therapeutic Recreational Director or designee, Certified Nursing Assistants (CNA), Human Resources, Maintenance Director,and Culinary Director. Required Staff Competencies (This is not an inclusive list and competencies requirements correlate to positional needs): · Person-centered care - This includes but not be limited to person-centered care planning, education of resident and family /resident representative about treatments and medications, documentation of resident treatment preferences, end-of-life care,and advance care planning. · Activities of daily living - bathing (e.g., tub, shower, bed), bed-making, toileting (including colostomy, urostomy needs), dressing, feeding, nail and hair care, perineal care (female and male), mouth care (brushing teeth or dentures), transfers, using gait belt, using mechanic lifts and other assistive devices.	F 725		

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F 725	Continued From page 71 · Disaster planning and procedures - elopement, fire, flood, power outage, tornado, disaster preparedness · Infection control- hand hygiene, isolation, standard universal precautions including use of personal protective equipment, environmental cleaning. · Medication administration - injectable, oral, subcutaneous, topical, g-tube, PICC line, sublingual, crushed medications, and rectal · Measurements: blood pressure, orthostatic blood pressure, body temperature, height and weight, radial and apical pulse, respirations, recording intake and output, · Specialized care - catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, trach care/suctioning, tube feedings, wound care/dressings	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 727		3/14/24

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F 727	Continued From page 72 The facility's request for a waiver was accepted and and approved by the State Agency following the survey exited 10/10/23. This will remain in effect until such time as the registered nurse (RN) coverage can be filled and the facility achieves compliance. F727: CFR 483.35 (b)(1), RN coverage 8 consecutive hours a day, 7 days a week. Findings include: Review of nursing schedule in the last 30 days identified no registered nurse (RN) had been scheduled on 2/1/24, 1/26/24, 1/21/24, 1/19/24, 1/17/24, 1/16/24, 1/13/24, 1/12/24, 1/10/24, 1/7/24, 1/6/24, 1/5/24. On 2/7/24 at 10:22 a.m., the administrator stated the facility had obtained a waiver for RN coverage and the facility was currently working on filling the RN positions and actively recruiting RN staff and offering incentives. During the interview the administrator stated the facility was using agency nursing staff to fill the RN coverage, was actively hiring RN's, was aware not all days had a scheduled RN, and confirmed the facility had a waiver. On 2/7/24 at 3:14 p.m. during an interview with human resources (HR)- stated the facility had multiple open positions and included RN nursing positions, and further stated finding licensed staff was difficult as they are non-existent.	F 727	F727 RN Coverage -The process for satisfying this requirement has been reviewed and revised as needed to ensure RN coverage is reviewed daily. -All residents in the facility have the potential to be affected if this requirement is not met. -Director of Nursing or nurse manager will provide RN coverage 8 hours a day, 5 days a week. Outside agency RNs will continue to be utilized to attempt to fulfill the daily RN coverage requirement. An RN is always available by phone for questions. Facility will continue to actively recruit and hire RNs. Facility offers sign on bonuses offered for RNs, referral and retention bonuses for current staff. Corporate recruiter is actively looking for RNs. -A waiver is in place from MDH for the 8-hour RN requirement. We have found it to be difficult to fulfill our 8 hours of RN coverage, 7 days a week, most notably on the weekends. We currently have several efforts in place to recruit RNs such as sign-on bonuses, retention bonuses for current staff, staff referral bonuses, and tuition reimbursement for our LPNs looking to further their nursing credentials. RN job postings can be found online on	

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F 727	Continued From page 73	F 727	Facebook, Indeed, and the Monarch Healthcare Management website. Weekly retention and recruitment meetings have been started with the Administrator, Human Resource Director, and Regional Corporate Recruiter. Bayside Manor utilizes several supplemental nursing agencies including: EShyft, ShiftKey, Clipboard, Grapetree, Divine, Evident, Healthcare Associates, Favor Staffing, and Minnesota Nurse Rescue. In addition, Monarch employes RNs through their own float pool. RN coverage is utilized through these agencies and pools when available, although due to the facility's location it can be difficult to find RNs through these methods as well. Knowing that it will become even more difficult for us to fulfill our 8 hours per day of RN coverage, we do, and will continue to, consider the acuity of our current residents as well as those who we review for admission if our request was approved. The health and safety of our residents is our top priority. The facilities Medical Director is aware of the RN staffing challenge, as well as the rounding physician. With the support of our interim Director of Nursing, corporate Regional Nurse Consultant, and outside agency floor RNs, we will continue to put forth every effort to have an RN in the building for at least 8 hours a day, 7 days a week, and ensure we always have an RN on call.	

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F 727	Continued From page 74	F 727	-Director of Nursing, Administrator, and Scheduler have all been educated on this requirement. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 03/14/2024.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		3/14/24

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F 755	Continued From page 75 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for periodic reconciliation of controlled substances for 2 of 2 (R20, R22) residents stored in a refrigerator. Findings include: On 2/7/24 at 7:41 a.m., a tour of the medication room included a locked refrigerator with a locked fixed metal container present. Licensed practical nurse (LPN)-A indicated she was not sure what the locked metal box was and had never received a code to open it or been told what was in it. On 2/7/24 at 7:45 a.m., registered nurse (RN)-C, also known as regional nurse consultant, entered the medication room and stated she was not aware of the metal locked box in the refrigerator. RN-C guessed what the pass code was and opened the box stating "if I got it right on the first attempt, the box isn't very secure". The locked box contained lorazepam, (schedule 4 medication used to treat anxiety) suspension 2 mg/milliliter (ml) 1 box, dispensed 2/3/23, with 22 ml's present per RN-C. RN-C added, this should be discarded after one year once opened. There were 3 other lorazepam suspension 2 mg/ml boxes present for R20, 2 of the boxes were open. One was received 11/9/23 with 28 mls in the container and one received 2/2/24 which appeared full. The	F 755	How corrective action will be accomplished for those residents found to have been affected by the deficient practice¿ R20 and R22's refrigerated controlled substances were reconciled on 02/07/24. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur¿ No other residents were affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur¿ Nurses and TMAs were educated on the facility process for reconciliation of controlled substances including refrigerated controlled substances. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will conduct random audits of periodic reconciliation of controlled substances to	

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F 755	Continued From page 76 unopened box included, date received as 1/9/24. On 2/7/24 at 7:50 a.m., LPN-A indicated she wasn't aware of controlled substances in the locked box and has not reconciled them at change of shift. On 2/7/24 at 8:05 a.m., LPN-C indicated she was not aware of locked container in the refrigerator, did not know what the pass code was and did not complete reconciliation this morning or any other shifts she has worked at the facility. On 2/7/24 at 8:15 a.m., RN-C indicated the medication was being logged into the narcotic book and put in the refrigerator by night staff upon arrival. RN-C indicated medication was not getting reconciled if staff were unaware of the combination code or that it was present in the locked box in the refrigerator. The Controlled Substance Storage policy dated 5/2022, included: Schedule II-V medications and other medications subject to abuse or diversion are stored in a permanently affixed double-locked compartment separate from all other medications or per state regulation. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented.	F 755	ensure it is occurring per facility process. Audits will be conducted daily x 5, weekly x3, monthly x2, and reported to QAPI committee for further review and recommendations.¿	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		3/14/24

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F 761	Continued From page 77 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure controlled medications were stored in a manner to prevent and minimize the risk of diversion for 1 of 1 medication storage rooms in the facility. Findings include: During observation and interview 2/7/24, at 7:41 a.m., in the medication room, licensed practical nurse (LPN)-A opened the locked refrigerator. A metal box was affixed to the shelf with dial lock present. On top of the affixed box was a plastic container identified by LPN-A as the Emergency kit (E-kit). LPN-A removed the plastic container from the refrigerator and indicated it has	F 761	How corrective action will be accomplished for those residents found to have been affected by the deficient practice¿ Polaris Pharmacy was notified on 02/07/24 with request to make adjustment to facility refrigerated ekit and no longer deliver injectable Ativan in the refrigerated ekit. Ekit was returned to the pharmacy and replaced with an updated kit that did not contain refrigerated controlled substances. How the facility will identify other residents having the potential to be affected by the	

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F 761	Continued From page 78 emergency insulin, lorazepam (schedule 4 medication used to treat anxiety) and other medications present in the E-kit. The E-kit was secured with a green breakaway lock. A label attached to the top of the plastic box stated "Refrigerated Emergency Drug Kit". Included in the E-kit, was multiple variations of insulin, and lorazepam injection 1 milliliter (ml) vial. The plastic container had individual compartments for each medication. During observation and interview on 2/7/24 at 7:45 a.m., registered nurse (RN)-C, also known as regional nurse consultant, indicated the plastic container was the E-kit medications and confirmed it included lorazepam injectable in the kit. RN-C was not aware of the affixed metal box under the E-kit in the refrigerator but confirmed the plastic container was not in the locked and affixed metal container. The facility Controlled Substances Storage policy dated 5/2022, included Schedule II-V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double locked compartment separate from all other medications or per state regulation. Controlled-substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator.	F 761	same deficient practice will not recur¿ All residents have the potential to be affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur¿ The facility has Ativan tablets available in MedBank emergency kit, these do not require refrigeration. Subsequent deliveries of refrigerated ekit do not contain controlled medications and this eliminates the requirement for the ekit to be stored in a permanently affixed refrigerated lock box. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will conduct random audits to ensure refrigerated ekit continues to be delivered without controlled medications. Audits will be conducted weekly x 4, monthly x 2 and reported to QAPI committee for further review and recommendations.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		3/14/24

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F 880	Continued From page 79 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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	245473	A. BUILDING _____ B. WING _____	C 02/07/2024

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F 880	Continued From page 80 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post visual alerts with instructions regarding current infection prevention recommendations for source controls at the facility entry door per Centers for Disease Control (CDC) recommendations. In addition, the facility failed to ensure proper infection control practice while removing medications from bottle for 1 of 2 residents (R30) and sanitize facility glucose monitor per manufacturer's recommendations for 1 of 1 (R12). Further, based on interview and document review, the facility failed to have a water management program consistent with nationally accepted standards, e.g., ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) or CDC. This had the	F 880	Plan of Correction¿(POC) Template How corrective action will be accomplished for those residents found to have been affected by the deficient practice¿ Facility entrance signs with current infection prevention recommendations were replaced on 02/07/24. Education was provided to TMA who did not follow the proper infection control practice while removing medications from bottle for R30. Education was also provided to RN who did not sanitize facility glucose monitor per manufacturer’s recommendations after	

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F 880	Continued From page 81 potential to effect all 30 residents who resided in the facility. Findings include: Upon arrival to the facility, the main entrance did not include signs indicating infection prevention recommendations for source control, hand hygiene or recommended actions to prevent transmission to others (positive Covid-19 test, symptoms or close contact with someone with Covid-19). During observation on 2/5/24 at 4:30 p.m., an exit door, locked from the outside, off the dining area, included a sign that included "Stop if you have any of the below symptoms, have recently tested positive for Covid-19 or been in close contact with someone confirmed to have Covid-19". During observation on 2/7/24 at 10:15 a.m., registered nurse (RN)-C, also known as the infection preventionist (IP), observed the exit door off the dining area and indicated that door has the correct sign but is locked and not used for entry. In the main lobby, RN-C observed the two entry doors and confirmed there were no signs present for visitors entering the facility for recommendations for infection control practices. RN-C indicated their are 2 recommended signs to be posted which include "Cover your Cough" and when not to visit. RN-C indicated if there is a current outbreak at the facility an additional sign will be posted with current number of Covid-19 cases and recommendations for source control use. The facility Covid Policy updated 9/26/23, included signage should also be posted to notify	F 880	R12's use. The facility completed a Legionella Risk Assessment, developed a detailed diagram of the facility water system, and implemented a program consistent with the nationally accepted standards from ASHRAE. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur¿ All residents have the potential to be affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur¿ Staff were educated on requirements for posting facility entrance signs, proper infection control practices for handling of medication, and disinfection of shared glucose monitoring equipment. Maintenance staff were educated on facility water management program standards and ASHRAE. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will conduct random audits for proper infection control practices related to medication administration and blood glucose monitor disinfection to ensure proper practice. Audits will be conducted daily x 5, weekly x2, monthly x2, and	

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F 880	Continued From page 82 those who enter to frequently perform hand hygiene; limit their interactions with others in the facility and surfaces touched; restrict their visit to the resident's room or other location designated by the facility during an outbreak and follow other current infection prevention and control standards (e.g., source control). MEDICATION ADMINISTRATION: During observation on 2/6/24 at 4:07 p.m., trained medication aide (TMA)-B completed hand hygiene and removed 2 bottles from the medication cart. TMA-B tipped the bottle dispensing 1 capsule of Detorex (supplement that may assist in maintaining health blood pressure levels) into her ungloved hand and placed in a medication cup. TMA-B tipped the bottle labeled NutriDyn Osteo Renew (medicaion used to support healthy bone metabolism) dispensing 1 capsule into her hand and placed in medicaion cup. TMA-B then put on gloves and administered medications to R30. During interview on 2/6/24 at 4:15 p.m., TMA-B indicated the medication should have been put directly into the medication cup and not into her hand. During interview on 2/7/24 at 9:59 a.m., registered nurse (RN)-C, also known as infection preventionist, stated medications should not be put directly into an ungloved hand but should be put into the cap from the medication bottle and then into the medication cup. RN-C confirmed touching medications is an infection control issue. The facility Medication Administration - General Guidelines, dated 5/2022 included	F 880	reported to QAPI committee for further review and recommendations.¿ Administrator or designee will conduct random audits to ensure facility entrance signs for current infection prevention recommendations are in place and that the facility water management program standards are implemented. Audits will be conducted weekly x4, monthly x2, and reported to QAPI committee for further review and recommendations.¿¿¿	

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F 880	Continued From page 83 - Handwashing and hand sanitization: The person administering medications adheres to good hand hygiene, which includes washing hand thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, before and after administration of ophthalmic, topical, vaginal, rectal and pretrial preparations and before and after administration of medications via enteral tubes. -Examination gloves are worn when necessary (refer to specific administration procedures for each route in Sections IIA and IIB of this manual. -Hand Sanitization is done with an approved sanitizer, between hand washings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface), and at regular intervals during the medication pass such as after each room. Sanitization is not a substitute for proper hand washing, and washing should be done if there is any question. -Tablet Splitting: if breaking tablets is necessary to administer the proper dose, hands are washed with soap and water or alcohol gel and examination gloves worn prior to handling tablets and examination gloves must be worn to prevent touching of tablets during the process. GLUCOMETER: During observation on 2/6/24 at 8:35 a.m., RN-E indicated they use one glucose machine for multiple residents. Registered nurse (RN)-E removed a white plastic basket that included cotton balls, glucometer (Assure Platinum	F 880		

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F 880	Continued From page 84 medical device for determining the approximate concentration of glucose in the blood) and single use lancets from the medication cart drawer. RN-E completed a glucose test for R12, disposed of lancet and placed glucometer back into white plastic basket removed gloves and performed hand hygiene. RN-E then placed white plastic basket back into drawer on medication cart. RN-B did not sanitize the glucometer before or after use. On interview on 2/6/24 at 9:06 a.m., when questioned RN-B what their disinfecting process for glucometers was, she indicated she cleans the glucometer before each use and just put the white plastic basket in the drawer to get it out of her way. Per manufacturer instructions this brand of glucometer device should be cleaned and disinfected after each use using a disinfectant detergent or germicide. On interview, 2/7/24 at 9:59 a.m., registered nurse (RN)-B, also known as infection preventionist, indicated the glucometer devices should be sanitized with purple top wipes (Super-Sani-Cloth used for disinfection in healthcare), allowed to dry before being put back into the container or there is risk of contaminating whatever else is in the container. Infection policies and procedures did not include use and cleaning of glucometer device. WATER MANAGEMENT PROGRAM: During interview and record review on 2/7/24 at 9:33 a.m., maintenance director (MD)-A stated he	F 880		

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F 880	Continued From page 85 was responsible for the water management program. MD-A explained actions he took related to the water management program which included running water in vacant resident rooms and measuring the temperature of the water coming out of resident faucets. MD-A was not aware of additional requirements of an effective water management program including conducting a Legionella risk assessment, creating a detailed diagram of the facility water system, and following a nationally accepted water management program. Together with MD-A, reviewed the facility policy titled Legionella Water Management Program dated 7/5/23, which listed many of the required elements of a water management program, however, MD-A stated he had not been aware of the policy. During an interview on 2/7/24 at 4:15 p.m., the administrator, who had provided the facility policy titled Legionella Water Management Program for review, was informed of findings related to the water management program; specifically, the lack of a Legionella risk assessment, lack of a detailed diagram of the facility water system, and failure to follow a nationally accepted water management program resource. The administrator was unaware MD-A was not familiar with the policy and stated she would work with him to understand the regulations. The facility Legionella Water Management Program policy dated 7/5/23, indicated as part of the infection prevention and control program, the facility had a water management program, which was overseen by the water management team. The purpose of the water management program was to identify areas in the water system where Legionella bacteria had potential to grow and	F 880		

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F 880	Continued From page 86 spread, and to reduce the risk of Legionnaire's disease. The water management program was based on the CDC and ASHRAE recommendations for developing a Legionella water management program. The water management program would include an interdisciplinary water management team and a detailed description and diagram of the water system in the facility and would include a plan for when control limits were not met and/or control measures were not effective. Although the facility water management program policy identified the appropriate measures for an effective water management program, not all the measures had been implemented, such as a risk assessment to determine vulnerabilities for Legionella, creation of a detailed description and diagram of the water system into the facility and the use of nationally accepted standards, e.g., ASHRAE or CDC.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/05/2024. At the time of this survey, Bayside Manor was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Bayside Manor LLC was constructed in 1974, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. In 2008, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 33 at time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.