



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 17, 2024

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: October 15, 2024

Dear Administrator:

On December 16, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 17, 2024

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

Re: Reinspection Results
Event ID: Z7BT12

Dear Administrator:

On December 5, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 15, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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November 4, 2024

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: October 15, 2024

Dear Administrator:

On October 15, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 15, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 15, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

Bayside Manor LLC

November 4, 2024

Page 4

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

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

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

PRINTED: 11/20/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2024
NAME OF PROVIDER OR SUPPLIER BAYSIDE MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 10/13/24-10/15/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 10/13/24-10/15/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54739391C (MN00106453) and H54739392C (MN00101186). 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			
F 550	Resident Rights/Exercise of Rights	F 550			11/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/12/2024

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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F 550 SS=D	Continued From page 1 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 reprisal from the facility in exercising his or her	F 550			

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F 550	Continued From page 2 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 resident rights and choices were protected for 1 of 1 resident (R16) when his recliner was removed from his room against his wishes. Findings include: R16's admission Minimum Data Set (MDS) dated 7/9/24, indicated an admission date of 7/3/24, intact cognition, no rejection of care, and diagnoses of heart failure, kidney failure, and edema. R16's care plan dated 7/9/24, focus area titled cognition indicated R16 was at risk for alteration in cognition related to adjustment to placement with interventions listed as allow resident time to communicate his needs/wants, provide and maintain consistent environment. R16's Physician's orders dated 7/2/24, indicated elevating legs to the level of the heart or above for 45-60 minutes, pump ankles while sitting in chair, elevate foot of bed, prop feet up on a pillow when sitting in recliner every shift. R16's Behavior note dated 7/4/24 at 3:37 a.m., indicated R16 was annoyed with staff due to not having his (personal) recliner at the facility yet from his prior facility. Notes further indicated R16 stated he slept in his chair, couldn't sleep in a bed, and needed his chair by that night.	F 550	-The process for satisfying this requirement has been reviewed and revised as needed to ensure resident rights are protected. -Residents residing in this facility have the potential to be affected. -All staff will receive education on resident rights regarding resident property. R16s recliner has been returned to his room. -IDT and resident will discuss residents items prior to removing any items from the room. Audit to be completed to ensure all of residents recliners remain in their rooms or appropriate steps and documentation is completed. -Audits will be completed two (2) times per week for 4 weeks, one (1) time per week for 2 weeks, and one (1) time per month for 1-month. -Social Services or Designee is responsible party. -Corrective action will be completed by 11/22/2024.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 550	Continued From page 3 R16's New Admission Note dated 7/5/24 at 3:38 a.m., indicated R16 had a hard time falling asleep that night because he was upset about not having his recliner from his prior facility. R16's New Admission Note dated 7/6/24 at 4:58 a.m., indicated R16's recliner had arrived from his prior facility, he was very happy to have his recliner since being without it since admission on 7/3/24, and was resting quietly in his recliner with his eyes closed. R16's Health Status progress note dated 9/15/24 at 3:37 a.m., indicated R16 rested well throughout the night and slept in his recliner with legs elevated for comfort. During interview on 10/14/24 at 8:31 a.m., R16 stated his recliner was taken from his room several days ago to be cleaned and he was unsure when it would be returned. R16 further stated he slept in his recliner every night and had been sleeping in his wheelchair since his recliner was removed. R16 stated he wanted to put his feet up but could not due to his recliner being gone. R16 further stated he did not sleep in his bed due to it being too small and uncomfortable. During interview on 10/14/24 at 2:03 p.m., R16 stated he did not give permission for his chair to be taken, he had asked for a sheet to be put over it instead, he was sick of sleeping in his wheelchair, and he wanted his chair back by evening. During observations from 10/13/24 through 10/15/24, R16 was observed in his wheelchair with his legs down on footrests. His personal recliner was absent from his room. An alternate			F 550			

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F 550	Continued From page 4 recliner from the facility common area was provided after 5 p.m. on 10/14/24. R16's personal recliner was returned on 10/15/24. During interview on 10/14/24 at 2:06 p.m., director of nursing (DON) stated R16's recliner was wet with urine and had a foul smell and she had to take it on 10/10/24 or 10/11/24. DON confirmed she did not ask permission to take the chair. DON further confirmed she was unsure who was going to clean the chair and if or when it would be returned. During interview on 10/15/24 at 10:20 a.m., social services director (SSD) stated she had not been involved in the conversation to remove R16's recliner and was informed after it was removed. SSD further stated R16's recliner was very important to him when he admitted to the facility, and she would have expected R16's chair to be cleaned and immediately returned or a replacement chair offered and accepted prior to removing the chair. SSD further stated due to resident rights, they should have had his permission to remove the recliner. During interview on 10/15/24 at 1:10 p.m., administrator stated they had a discussion about the recliner and decided to remove it due to odor and infection control. Administrator stated she was unsure if anyone confirmed permission from R16. A policy on resident rights and personal property was requested but not received.	F 550			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641			11/22/24

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F 641	Continued From page 5 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 1 resident (R5) reviewed for hospice. Findings include: R5's Face Sheet dated 10/15/24, indicated R5 primary payer was hospice, care providers included hospice, and diagnoses hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (conditions that cause weakness or paralysis on one side of the body after a stroke), dementia, and altered mental status. R5's significant change in status MDS dated 9/17/24, section O, K1 under special treatments and programs, did not include hospice care services . Section J 1400 Prognosis: conditions or chronic diseases that may result in a life expectancy of less than 6 months indicated no. R5's hospice plan of care printed 10/15/24, indicated R5's hospice start of service date was 9/11/24. R5's care plan dated 10/13/24, indicated hospice Cares r/t (related to) end stage kidney disease, enrolled for services with hospice. On 10/15/24 at 11:49 a.m., registered nurse (RN)-A, also identified as MDS specialist,	F 641	-R5s MDS has been modified to reflect Hospice. All hospice residents most recent MDS' have been audited to appropriately reflect Hospice coding. -All hospice residents had the potential to be affected. -MDS Coordinator has been educated on appropriately coding Hospice on an MDS. MDS hospice coding will be discussed in the IDT morning stand up meetings to review any MDS that are due to ensure Hospice has been coded. -Administrator or designee will conduct random audits of coding Hospice on the MDS. Audits will be completed weekly x4 and monthly x2. -Corrective action will be completed by 11/22/2024.		

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F 641	Continued From page 6 indicated R5 was admitted to the facility on hospice. Upon review of admission MDS, RN-A confirmed section 0 was not coded as R5 receiving hospice services. On 10/15/24 at 12:37 p.m., the director of nursing (DON) stated the MDS should have been completed accurately and hospice services should have been indicated on the admission MDS. On 10/15/24 at 2:54 p.m., the administrator stated the facility followed the RAI (resident assessment instrument) Manual and doesn't utilize a specific MDS policy.	F 641			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow physician orders for leg elevation for 1 of 1 resident (R16) reviewed for edema. Findings include: R16's admission Minimum Data Set (MDS) dated 7/9/24, indicated intact cognition, no rejection of	F 684	How corrective action will be accomplished for those residents found to have been affected by the deficient practice¿ - R16 was provided recliner to allow for leg elevation per physician orders How the facility will identify other residents		11/22/24

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F 684	Continued From page 7 care, and diagnoses of heart failure, kidney failure, and edema. R16's care plan dated 7/9/24, focus area titled cognition indicated R16 was at risk for alteration in cognition related to adjustment to placement with interventions listed as allow resident time to communicate his needs/wants, provide and maintain consistent environment. Care plan focus area titled skin integrity indicated R16 had alteration in skin integrity related to congestive heart failure (CHF), diabetes mellitus type two (DM2), chronic gout as evidenced by (AEB) wounds. Interventions included encouraging resident to sleep in his bed, monitoring skin integrity, and pressure reducing devices to bed and recliner. R16's Physician's orders dated 7/2/24, indicated elevating legs to the level of the heart or above for 45-60 minutes every shift, pump ankles while sitting in chair, elevate foot of bed, prop feet up on a pillow when sitting in recliner. During interview on 10/14/24 at 8:31 a.m., R16 stated his recliner was taken from his room several days ago to be cleaned and he was unsure when it would be returned. R16 further stated he slept in his recliner every night and had been sleeping in his wheelchair and had not elevated his feet since his recliner was removed. R16 stated he wanted to put his feet up but could not due to his recliner being gone. During interview on 10/14/24 at 1:22 p.m., R16's family member (FM)-J indicated she had not observed his legs elevated since removal of his recliner. FM-J further stated R16 had been sleeping in his wheelchair with his legs down	F 684	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; Order process for implementation of providers orders for all residents to be reviewed. Education to be provided to nursing staff. Education to be provided to nursing staff on following providers orders and proper documentation. 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 audit of providers orders for elevation of feet to ensure compliance of all residents with leg elevation orders. Audits will be completed weekly x 4, monthly x 2, and reviewed with QAPI committee for further review and recommendations. Corrective action will be completed by 11/22/2024.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 684	Continued From page 8 since removal of his recliner and the only option he had been given was to sleep in his bed for elevation, which he didn't like due to the bed being too short and hard. FM-J stated the facility was aware R16 did not like the bed. During interview on 10/14/24 at 10:45 a.m., nursing assistant (NA)-A stated R16 usually sat in his recliner with his legs elevated. NA-A further stated she did not know how he would elevate his legs in his wheelchair or if his legs had been elevated since his recliner had been removed from his room. NA-A also stated R16 usually slept in his recliner. During interview on 10/14/24 at 1:49 p.m., registered nurse (RN)-B stated R16 had been without his recliner since the middle of last week. RN-B further stated he had been sleeping in his recliner and elevating his legs in his recliner prior to it being removed. RN-B was unsure if R16's order for elevating his legs had been completed since his recliner was removed and it would be concerning if R16 was not elevating his legs due to his edema. During interview on 10/14/24 at 2:32 p.m., licensed practical nurse (LPN)-A also known as care coordinator stated they had offered to put R16 in bed to take swelling down in lower legs and feet but he refused. LPN-A further stated he often refused to elevate his legs. LPN-A stated she was unsure if R16's legs had been elevated since his recliner was removed and she would check the nurse charting. During interview on 10/24/24 at 2:06 p.m., director of nursing (DON) stated she was unsure if R16's legs were being elevated since his chair	F 684			

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F 684	Continued From page 9 was removed. DON stated she talked to R16 and he told her he had not been sleeping in his bed and had been in his wheelchair since his recliner was removed from his room. DON further stated R16 frequently refused to elevate his legs and she would have expected staff to inform her if R16 was unable to elevate his legs and was sleeping in his wheelchair with his legs down. R16's treatment administration record (TAR) dated 10/1/24 through 10/14/24, indicated no refusals of leg elevation during the time period. A facility policy on edema was requested but not received.	F 684			
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 review, the facility failed to conduct a comprehensive reassessment after a fall incident and ensure new interventions were implemented to prevent further falls for 1 of 1 resident (R11) reviewed for falls. Findings include: R11's admission record printed 10/15/24,	F 689	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; - A comprehensive assessment was completed for R11's 09/29/24 fall and appropriate intervention was identified. R11 no longer resides at the facility.		11/22/24

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F 689	Continued From page 10 indicated diagnoses of chronic obstructive pulmonary disease (a lung disorder), muscle weakness, and history of falling. R11's admission Minimum Data Set (MDS) dated 9/27/24, indicated severe cognitive impairment, no rejection of care, use of a wheelchair for mobility, substantial assistance with transfers, and fall history prior to admission. R11's facility Kardex printed 10/14/24, indicated independent with toileting, assist of one staff with bathing, shaving, dressing, and bed mobility, assistance of one staff, walker, and gait belt for walking, and safety intervention of gripper socks at bedtime. R11's care plan dated 10/11/24, listed focus area of fall risk related to COPD, epilepsy, muscle weakness, and history of falls. Interventions included gripper socks or shoes to feet when not in bed and follow PT and OT instructions for mobility function. R11's progress note dated 9/28/24, listed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. R11's progress note dated 9/29/24, indicated R11 attempted to self-transfer to the bathroom from his bed and had a fall. Staff educated R11 on call light use and waiting for assistance. R11 had a skin tear to right knee from the fall. A facility incident review and analysis dated 9/29/24, was started but not comprehensively completed. The incident review and analysis lacked review of the fall to determine cause and intervention to prevent future falls. In addition, no			F 689	How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur; All residents with falls 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; Reviewed MHM Fall Prevention and Management policy. Education provided to nurse managers on MHM Fall Prevention and Management policy and the facility expectations for completion of the comprehensive assessment following falls. An audit of recent falls was completed to ensure the completion of a comprehensive assessment and implementation of appropriate interventions. 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 11 new intervention was identified on the care plan. A facility incident note dated 10/11/24, indicated R11 had an additional fall on 10/11/24 at 4:25 a.m., when found on the floor next to his bed after attempting to walk to the bathroom independently. An incident review and analysis was completed after this fall and intervention including gripper socks when out of bed. During observation on 10/13/24 at 1:16 p.m. and 2:33 p.m., R11 was observed walking in the hall without walker or staff assistance. During interview on 10/14/24 at 9:40 a.m., nursing assistant (NA)-B indicated she was not aware of what interventions were in place for R11 other than having him wear gripper socks. During interview on 10/15/24 at 10:00 a.m., licensed practical nurse (LPN)-A stated no comprehensive fall assessment had been completed after R11's fall on 9/29/24. LPN-A further stated an interdisciplinary team (IDT) risk assessment meeting was held on 9/30/24 and R11's fall was reviewed with suggested intervention of leaving R11's walker next to his bedside. LPN-A confirmed the intervention was discussed at the meeting but a fall assessment had not been completed and the intervention had not been implemented or added to the care plan. LPN-A stated without the intervention on the care plan staff would not be able to see it on their Kardex tool and would not know the intervention had been put in place. During interview on 10/15/24 at 12:28 p.m., director of nursing (DON) stated she would expect a post fall assessment done within 48	F 689	Director of Nursing or designee will conduct random audits of facility falls to ensure appropriate completion of comprehensive assessment and implementation of appropriate interventions. Audits will be conducted weekly x 4, monthly x 2, and reviewed with QAPI committee for further review and recommendations. -Corrective action will be completed by 11/22/2024.		

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F 689	Continued From page 12 hours of a fall and an intervention be put in place immediately, reviewed at the next facility risk management meeting, and then placed on the care plan. DON confirmed R11's fall dated 9/29/24, was discussed at the facility risk management meeting and an intervention of leaving R11's walker at bedside was discussed but had not been implemented. DON further stated timely implementation of interventions was important for reducing fall risk for residents. Facility policy Fall Prevention and Management updated 2/2024, indicated the following; Assessing and Evaluating Falls and Causal Factors When a fall occurs: Nursing staff will complete an incident review and analysis. Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and minimize complications from falling. Staff may implement relevant interventions to try to minimize serious consequences of falling and monitor and document each resident's response to interventions.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690			11/22/24

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F 690	Continued From page 13 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow provider's order of catheter flush for 1 of 1 resident (R12) reviewed with indwelling catheter to minimize the risk for urinary tract infections (UTI). Additionally the facility failed address urinalysis (test of the urine to detect infection) results for 2 of 2 residents (R5 and R12) reviewed for UTI. Findings include: R5's significant change Minimum Data Set (MDS) dated 9/17/24, indicated R5 was dependent on			F 690	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; - R12 is being monitored to ensure completion of catheter flush per provider orders. R12 and R5 UA/UC results were obtained and treated per provider order. R5's 09/24/24 UC results were confirmed to be sensitive to the ordered antibiotic. How the facility will identify other residents		

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F 690	Continued From page 14 staff for toileting hygiene, toilet transfer, and utilized a wheelchair, frequently incontinent of urine, taking an antibiotic, diagnoses included: chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (conditions that cause weakness or paralysis on one side of the body after a stroke), dementia, and altered mental status R5's care plan dated 10/13/24, indicated alteration in elimination r/t (related to) dx (diagnosis) of urinary incontinence, will be free from signs/symptoms of UTI, obtain/review labs per MD (medical doctor) order R5's progress note dated 9/10/24 at 3:09 p.m., the director or nursing (DON) indicated R5 returned from hospital and does have a UTI, antibiotics initiated. R5's progress note dated 9/10/24 at 5:24 p.m., registered nurse (RN)-B indicated R5 returned from the hospital with an order for cefdinir (antibiotic used to treat infections) 300 mg bid (twice a day) for 7 days due to a UTI. Family aware. Order faxed to pharmacy. R5's document transfer report dated 9/10/24, emergency provider notes dated 9/10/24, indicated R5 urinalysis consistent with UTI, will plan to discharge back to facility with prescription for cefdinir pending urine culture. R5's urine culture results with a fax dated 9/24/24, to the facility indicated R5's urine culture results. The document did not list the the current antibiotic, cefdinir, R5 was prescribed.			F 690	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¿– Reviewed lab result and order transcription process. Education provided to nursing staff and Health Information Manager on the process for addressing urinalysis results. Education provided to nursing staff on following providers orders and appropriate documentation. An audit of all recent UA/UCs was completed to ensure appropriate follow up. No other residents currently have catheter flush orders. 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 urinalysis results to ensure appropriate follow up and of catheter flush completion to ensure compliance. Audits will be completed weekly x 4, monthly x 2, and reviewed with QAPI committee for further view and recommendation. -Corrective action will be completed by 11/22/2024.		

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F 690	Continued From page 15 R5's record review failed to indicated R5's urine culture results were addressed by the facility. On 10/15/24 at 11:11 a.m., licensed practical nurse (LPN)-A, known as the nurse manager, stated the urine culture result was scanned into electronic medical record (EMR) without the nurse reviewing the result. LPN-A stated the results are dated and signed by the nurse when reviewed. LPN-A stated health information was expected to make sure documents were signed and dated by a nurse prior to scanned into the EMR to ensure results were addressed. LPN-A confirmed R5's UC result dated 9/10/24, and faxed to the facility 9/23/24, was not reviewed by a nurse as expected and was important to ensure R5 was on the correct antibiotic for her UTI. On 10/15/24 at 12:26 p.m., during a telephone call consulting pharmacist stated the facility was expected to timely review and address urine culture results and follow up with the provider regarding UC results. CP-A stated failure to address or follow up with the provider regarding urine culture results can lead to ineffective treatment, specifically, if the prescribed medication is not susceptible with the culture results, it may exacerbate the infection or prolong treatment. On 10/15/24 at 12:37 p.m., the DON, stated the nurse manager were expected to be aware of residents who had a UC pending and confirmed there was a "breakdown" in the process. The DON further stated HIM was not expected to scan documents in the EMR until signed and dated by nursing. On 10/15/24 at 1:33 p.m., health information	F 690			

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F 690	Continued From page 16 management (HIM)-D stated she scanned documents in the EMR, and confirmed the documents were expected signed and dated prior to scanned into the EMR. HIM-D stated documents not signed or dated by nursing were expected brought back to nursing to ensure the document or order was reviewed and entered. HIM-D stated UA's and UC's results were also expected signed and dated prior to scanned into the EMR. HIM-D confirmed documents were scanned into the EMR without nurse signature or date and the facility had provided education ensuring nursing had reviewed prior to her scanning into the EMR. R12's quarterly MDS dated 8/7/24, indicated R12 was cognitively intact, had an indwelling urinary catheter, dependent on staff for toileting hygiene and toilet transfers, utilized a wheelchair, diagnoses included traumatic spinal cord dysfunction, neurogenic bladder (a condition that affects bladder control due to nerve damage or brain disorders), and quadriplegia (paralysis that affects all of a person's limbs). R12's physician orders start date 6/26/24, indicated flush and irrigate catheter every other day with 60 cc (cubic centimeter) normal saline for oliguria (low urine output) and progress note needed at 8:00 p.m. R12's treatment administration record (TAR) dated 9/1/24-9/30/24, indicated the provider order flush and irrigate catheter every other day with 60 cc normal saline for oliguria and progress note needed scheduled at 8:00 p.m., was completed 10 out of the 15 times, and was not completed five times.	F 690			

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F 690	Continued From page 17 R12's progress note dated 9/27/24 at 6:13 a.m., licensed practical nurse (LPN)-B indicated R12 was bypassing her catheter catheter, nurse flushed her catheter at that time, there was 250 cc out at the time she flushed it. R12's progress note dated 9/28/24 at 5:37 a.m., LPN-B indicated R12's brief was wet, nurse flushed her catheter and emptied her bag to ensure that it was following [flowing] properly, catheter has sediment that was clogging it. R12's progress note dated 10/3/24 at 3:53 a.m., LPN-B indicated R12 requested for her catheter flushed because she could feel it bypassing, nurse flushed it and had CNA's apply a brief. R12's progress note dated 10/7/24 at 4:30 a.m., LPN-B indicated R12 was having trouble with her catheter, R12 indicated her catheter had been clogged for a while and they had to change her brief a total of six times, nurse attempted to flush her catheter without any success, there was so much sediment that the water was not going through. Nurse then proceeded to change her catheter, it is currently patent, she had 700 cc's out. Nurse sent an email to the provider requesting an order for UA/UC, her urine is dark, odorous, and full of sediment. The lat time time it was changed was eight days ago, she is to have it changed every 14 days , but it has not been lasting that long. R12's progress note dated 10/9/24 at 5:33 a.m., LPN-B indicated nurse applied a new catheter bag and collected a UA, urine dark with slight odor, a lot of sediment, urine sample in the refrigerator, waiting for it to be sent to lab.	F 690			

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F 690	Continued From page 18 R12's progress note dated 10/11/24 at 1:45 p.m., LPN-A indicated writer collected UA and sent over with order to pharmacy, awaiting results. R12's progress note dated 10/12/24 at 12:54 a.m., LPN-B indicated received the UA results from lab department, the following results were abnormal; urine appearance was turbid (murky or unclear, instead of its normal clear or slightly cloudy appearance), urine ph is higher than 9 (normal urine pH ranges from 4.6 to 8.0), urine leukocyte esterase 3 (sign of infection), urine protein 3 (can be a sign of kidney problems), urine blood 2 (sign of infection), results faxed to provider waiting for response. On 10/13/24 at 6:16 p.m., R12 was seated in her motorized wheelchair in her room with family member (FM)-E. R12 stated she had problems with her urine and clogging of the catheter tubing within the last month. R12 stated staff were supposed to flush the catheter every other day so sediment does not build up in the catheter tubing. R12 stated the staff do not routinely flush the catheter tubing every other day. R12 stated she had in the last month problems with the catheter not flowing properly due to the sediment built up and was urine was leaking around the catheter and she had to wear a brief due to the urine leaking from the catheter. R12 stated she had a recent urine collection to see if she had an infection and stated she must not because she had not heard from the staff. R12 stated the urine test was due to the smell, dark color, and lots of sediment in the urine. FM-E stated R12 had never had a UTI prior to her admission the facility. On 10/15/24 at 9:59 a.m., physician assistant (PA)-H stated he was R12's medical provider and	F 690			

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F 690	Continued From page 19 comes to the facility once a week. PA-H stated the facility was expected to fax UA results on the weekend to the on call provider and was not aware of any pending UA results for R12. PA-H stated the staff were expected to follow the order and flush R12's catheter every other day. PA-H stated not flushing the catheter every other day could cause sediment to build up and could cause a UTI. PA-H stated staff were expected to follow up with the provider within 24 hours if a provider had not addressed a residents UA results. On 10/15/24 at 10:56 a.m., LPN-A, known as the nurse manager stated R12 was known to have sediment build up in her catheter. LPN-A stated she was not aware staff were not flushing R12's catheter as ordered every other day, and would expect staff follow provider orders LPN-A was observed to check the EMR for R12 and confirmed there were five dates in September when R12's catheter was not flushed as ordered. LPN-A stated R12 had problems with her catheter not flowing and her catheter leaking and R12 had to wear a brief. LPN-A stated R12's catheter not flushed could cause sediment to build up. LPN-A further stated a UA was cooled on 10/11/24, and the results were faxed to the provider on 10/13/24, and confirmed the UA result had not been addressed by the provider, LPN-A further stated the facility was responsible to follow up within 24 hours if a result was not addressed by the provider. On 10/15/24 at 12:53 p.m., the DON stated staff were expected to follow provider orders and flush R12's catheter every other day. The DON stated nurse managers were expected to run a daily report that indicates residents missed orders. The	F 690			

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F 690	Continued From page 20 DON was observed to run report on the EMR and confirmed R12 had missed catheter flushes in September. The DON stated the catheter flushes were important so sediment does not build up and could cause a UTI. The DON stated she has educated facility staff all orders were expected completed prior to staff leaving their shift. Further, the DON stated R12's UA result from 10/13/24 was expected to be addressed by the provider and if not addressed would expect the nurse manager to reach out the provider within 24 hours. Policy on UA/UC results was requested and not received. Facility policy Infection Prevention and Control Program dated 3/13/23, indicated : The infection prevention and control committee is responsible for reviewing and providing feedback on the overall program. s surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include: a. whether physician management of infections is optimal; b. whether antibiotic usage patterns need to be changed because of the development of resistant strains; c. whether information about culture results or antibiotic resistance is transmitted accurately and in a timely fashion; and d. whether there is appropriate follow-up of acute infections Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.	F 690			

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F 690	Continued From page 21	F 690			
F 756 SS=D	2. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756			11/22/24

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F 756	Continued From page 22 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the provider's response to the monthly medication review was followed for 1 of 5 (R18) residents reviewed for unnecessary medications. Findings include: R15's quarterly Minimum Data Set (MDS) dated 9/11/24, indicated R15 had moderate cognitive impairment, diagnosis included diabetes mellitus, and received insulin injections. R15's consultant pharmacist (CP)-A recommendation to physician dated 9/10/24, indicated consider redrawing A1C (measures your average blood sugar levels over the past three month) and adjusting insulin doses as needed. The provider responded to the recommendation on 9/17/24, and ordered A1C. R15's provider and nursing orders were reviewed and lacked documentation the facility had completed the physician ordered A1C. On 10/15/24 at 7:28 a.m., licensed practical nurse (LPN)-A confirmed R15's physician ordered A1C was not addressed by nursing staff as expected. LPN-A stated the order for the A1C was not sent to nursing before the order was scanned into the	F 756	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Provider orders received 09/17/24 have been addressed for R15. An A1C was collected and reviewed by the provider for R15. 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. Polaris Medication Review policy and workflow of orders from point of origination, processing, and finalization of being scanned in to be reviewed for all residents. Education to be provided to nursing staff and health information manager to ensure proper workflow and review. Audits to be completed on all residents of the most recent drug regimen review recommendations and orders to ensure appropriate follow through.		

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F 756	Continued From page 23 electronic medical record (EMR) by health information management (HIM)-A. LPN-A stated HIM-A was expected to make sure documents including orders were signed and dated by a nurse prior to scanned into the EMR to ensure orders were addressed. On 10/15/24 at 12:51 p.m., the director of nursing (DON) stated the pharmacist emailed the nurse managers with the provider recommendations, and stated the nurse managers were responsible to follow up with the pharmacy recommendations and provider response. The DON stated she would expect HIM to bring the order back to nursing if the order was not signed and dated by nursing. The DON stated she would expect the order for 9/17/24, addressed and completed.	F 756	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 the monthly drug regimen review to ensure follow through. Audits will be conducted monthly x3 and reviewed with QAPI committee for further review and recommendations. Corrective action will be completed by 11/22/2024.		
F 812 SS=F	A facility policy was requested and not received. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812			11/22/24

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F 812	Continued From page 24 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dietary staff followed appropriate infection control practices when handling cups and performing hand-hygiene during food service in the dining room and passing meal trays to resident rooms. In addition, the facility failed to ensure dishwasher chemical sanitization solution was monitored to ensure dishes were properly sanitized. This had the potential to affect all 34 residents who resided in the facility. Findings include: Meal tray delivery On 10/13/24 at 11:52 a.m. dietary aide (DA)-C was observed and pushed a cart with meal trays through the hallway and entered R20's room. R20 was observed lying in bed and DA-C placed R20's tray on R20's stomach area. DA-C used bare hands and touched R20's bed remote to adjust R20's bed, moved R20's bedside table, and touched R20's blankets on her bed. DA-C was observed to exit R20's room and failed to disinfect hands. DA-C proceeded to push the meal cart through the hallway and entered R50's room with a meal tray and used bare hands and gave R50's family member a glass of apple juice from the meal tray, and then DA-C exited the room with no hand washing observed entering or exiting R50's room. DA-C proceeded to push the meal cart through the hallway and entered R51's room with a meal tray. R51 was seated in a	F 812	Based on observation, interview, and document review, the facility failed to ensure dietary staff followed appropriate infection control practices when handling cups and performing hand hygiene during food service in the dining room and passing meal trays to resident rooms. In addition, the facility failed to ensure dishwasher chemical sanitization solution was monitored to ensure dishes were properly sanitized. This had the potential to affect all 34 residents who resided in the facility. -Dishwasher sanitation levels are within the appropriate range. Handwashing or sanitizing hands is being completed at appropriate times when handling food or entering/exiting a residents room. Staff are appropriately handling dinnerware. -All residents have the potential to be affected. -All culinary staff have been educated on the Handwashing Policy, Dishwashing Machine Use Policy, and proper handling of dinnerware. Staff have been educated on what actions to take if the dishwasher sanitization levels are not in the appropriate range. -Culinary Director or Designee will conduct random audits of handwashing,		

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F 812	Continued From page 25 recliner with a tray table in front of the recliner, DA-C placed the meal tray on a tray table placed in front of R51. DA-C with ungloved hands, opened the seal off a butter container, and took of clear plastic wrap off a piece of pie, then picked a piece of debris off the floor and placed in R50's garbage, and used a Kleenex to pick a bug off the floor and placed in R50's garbage and exited the room with no hand hygiene observed, and pushed the two meal carts through the hallway back into the kitchen. On 10/15/24 3:35 p.m. dietary director (DD)-F stated dietary staff were expected to complete hand hygiene prior to entering and exiting a resident room during meal delivery. Dining room food service During observations on 10/13/24, at 12:07 p.m., culinary services aide (CSA)-B was passing beverages to residents seated in the dining room. CSA-B was observed holding plastic drinking cups by the rim when serving juice and water to R5. At 12:17 p.m., CSA-B served chocolate milk, juice, and water to R16, holding cups by the rim when setting them on the table. During observation on 10/14/24, at 11:58 a.m., CSA-A passed beverages to residents R8 and R19, holding cups by the rim. At 12:11 p.m., CSA-A was observe picking her nose or teeth (not able to clearly determine which) and did not clean hands before serving beverages to R4. During an observation and interview on 10/14/24, at 12:24 p.m., observed CSA-A put her finger in her right ear. CSA-A was informed of the observations and the need to clean her hands after touching any part of her body before passing	F 812	dishwasher sanitation, and proper handling of dinnerware to ensure compliance. Audits will be completed weekly x4 and monthly x2. Corrective action will be completed by 11/22/2024.		

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F 812	Continued From page 26 beverages or food to residents. CSA-A stated she touched her face a lot -- it was a habit. CSA-A was also informed of observations of her holding cups by the rim as she placed them on tables. CSA-A stated she understood a resident would place his/her mouth on the rim and stated she should hold the cup closer to the bottom. During an interview on 10/15/24, at 9:55 a.m., CSA-B was taken aside and with a cup, asked to demonstrate the proper way to hold it when serving residents. CSA-B held it by the lower half of the cup. Surveyor informed CSA-B of observations on 10/13/24, when she held cups by the rim. CSA-B stated she had training on the proper way to hold a cup when serving residents and was not aware she held it by the rim. CSA-B stated she understood the rim was where a resident would place his/her mouth. Dishwasher Chemical Sanitation During an observation and interview on 10/15/24, at 10:05 a.m., observed CSA-B test the chemical sanitizing solution at the dishwasher using a chlorine test strip. The dishwasher had been in use immediately prior to this. The test strip measured 25 parts per million (PPM). CSA-B was asked to run another load and test it again. Again, it measured 25 ppm. According to facility policy, the chemical solution should test at 50-100 ppm. The culinary services director (CSD)-F was requested to test the solution, which also tested at 25 ppm. CSD-F stated he would contact the dishwasher vendor. CSD-F stated he did not do periodic spot checks to ensure staff were performing testing properly and according to policy. CSD-F stated staff received training for testing the sanitizing solution upon hire, but he	F 812			

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F 812	Continued From page 27 didn't document the content of the training, or when the training occurred. The water temperature on the dishwasher read 120 degrees Fahrenheit (F) which was correct according to regulation, but both CSA-B and CSD-F thought the temperature needed to be 150 degrees F. A paper log titled Dishwashing Record Low Temperature/Chemical posted on the wall by the dishwasher indicated for the month of October, three times a day, all ppm were read as 50 ppm and all but three water temperatures read as 150 degrees F. The log for September indicated the same. The log for August indicated ppm ranging from 10 to 50 ppm and temperatures ranging from 83 to 150 degrees F. During a telephone interview on 10/15/24, at 3:28 p.m., vendor representative (VR)-G for the dishwasher stated the facility utilized a low temperature unit. VR-G stated the water temperature should be set at 120 degrees F, and the chemical sanitizing solution should test between 50-100 ppm. While talking to VR-G, CSD-F came to the conference room and stated the test strips were "darker" now, but still not up to 50 ppm. Over speaker phone, VR-G advised CSD-F to switch to paper products until the dishwasher unit could be serviced, which CSD-F stated had been arranged for on 10/16/24. Facility Dishwashing Machine Use policy dated 2001, indicated food service staff required to operate the dishwashing machine would be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. A supervisor would check the dishwashing machine for proper concentrations of sanitizer solution (measured as parts-per-million [PPM] or mL/L)	F 812			

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F 812	Continued From page 28 after filling the dishwashing machine and once a week thereafter. Concentrations would be recorded on a facility approved log. Corrective action would be taken immediately if sanitizer concentrations were too low. The operator would check temperatures using the machine gauge with each dishwashing machine cycle and would record the results on a facility approved log. The operator would monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures would be reported to the supervisor and corrected immediately. If hot water temperatures or chemical sanitation concentrations did not meet requirements, the dishwashing machine would cease immediately until temperatures or PPM were adjusted. Type of Solution: chlorine, and minimum concentration 50-100 ppm.	F 812			
F 880 SS=D	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 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,	F 880			11/22/24

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F 880	Continued From page 29 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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 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.			F 880			

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F 880	Continued From page 30 §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 ensure personal protective equipment (PPE) was utilized for 1 of 2 residents (R136) reviewed for enhanced barrier precautions (EBP). Additionally, the facility failed to ensure proper glove use and hand hygiene was performed during wound care for 1 of 3 residents (R136) reviewed for pressure ulcers. Finding include: R136's admission Minimum Data Set (MDS) dated 10/3/24, indicated no cognitive impairment, one stage two pressure ulcer present on admission, two unstageable pressure ulcers present on admission, and diagnosis included stage two pressure ulcer of sacral region. R136's care plan printed 10/15/24, indicated R136 was on enhanced barrier precautions due to wound to coccyx requiring treatment and interventions included: staff to follow enhanced barrier precautions, use appropriate communication to follow EBP, explain reason for use of enhanced barrier precautions, staff to don/doff PPE per enhanced barrier precautions when providing high contact cares; admitted with ulcer on coccyx from prior facility and redness to right heel and interventions included: treatment to			F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice¿ - R136 no longer resides at the facility. 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¿ Reviewed Monarch's Enhanced Barrier Precaution and Wound Care Treatment procedures. Education will be provided to nursing staff, therapy department and housekeeping on regarding EBP policy and expectations. Wound Care Competencies will be completed on nursing staff to ensure compliance.		

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NAME OF PROVIDER OR SUPPLIER BAYSIDE MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
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F 880	Continued From page 31 open areas per order, weekly measurements and assessment of wound. On 10/14/24 at 8:48 a.m., a sign was observed on R136's door and indicated Enhanced Barrier Precautions, ... providers and staff must wear gloves and gown for the followingtransferring, providing hygiene, wound care. A cart outside of R136's room was observed with PPE and included gowns and gloves. Trained medication aide (TMA)-A and nursing assistant (NA)-B entered R136's room and failed to don PPE, and were observed to use a mechanical lift to transfer R136 from the wheelchair to the bathroom. TMA-A and NA-B used bare hands to move R136's feet from the wheelchair onto the mechanical lift and NA-B was observed to pull down R136's brief with ungloved hands. On 10/14/24 at 1:17 p.m. TMA-A confirmed no PPE was worn during the transfer of R136 earlier in the day. TMA-A stated gown and gloves were expected to be worn during transfers for residents placed on EBP. On 10/15/24 at 7:37 a.m., NA-C entered R136's room and put on gloves and assisted R136 with removing his shirt and washed R136's upper body with gloved hands and no gown. NA-C further was observed to remove R136's pants and removed the fastening tabs from R136's brief and washed R136's peri area with gloved hands and no gown. R136's coccyx had a dressing cover the pressure area. On 10/15/24 at 8:15 a.m., licensed practical nurse (LPN)-C entered R136's room with gloves, gown, and wound care supplies. NA-C (with gloved hands and no gown) and LPN-C turned R136 to	F 880	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 appropriate PPE use, proper glove use and hand hygiene during wound care review for efficacy and resident outcomes. This audit will be 3x per week for 2 weeks, weekly x 2, monthly x2, and reviewed with QAPI committee for further review and recommendations -Corrective action will be completed by 11/22/2024.		

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F 880	Continued From page 32 his right side in bed. LPN-A with gloved hands, removed the old dressing from R136's buttock, sprayed the wound with wound cleanser, used same gloved hands and opened a gauze package and used the gauze to dab the wound. NA-C (gloved not gowned), assisted LPN-C and again rolled R136 side to side and R136's brief was removed. LPN-C sprayed the wound again, measured the wound, and applied cream with same gloved hands, opened a clean dressing and placed the dressing on the wound, then applied skin prep around the wound . LPN-C further opened another dressing with same gloved hands and placed the dressing on the buttocks area, and then grabbed a clean brief and with assistance of NA-C a new brief was placed on R136. LPN-C removed gloves and placed in the trash and removed gown and exited R136's room. On 10/15/24 at 8:24 a.m., LPN-A confirmed gloves were not changed during R136's wound care and stated he was expected to change gloves and complete hand hygiene after removing the old dressing and place new clean gloves on prior to applying the new dressing. LPN-A stated gown and gloves were expected during wound care, however was not sure if staff had to wear PPE if they were not completing wound care and were assisting with the transfer. LPN-A proceeded to read the sign on R136's door and stated after reading the sign staff were expected to wear gown and gloves with transfers, hygiene, and dressing the resident with EBP. On 10/15/24 at 8:26 a.m., NA-B confirmed gloves or gown was not worn when she toileted or transferred R136. NA-B stated the facility had not provided education that PPE including gown and	F 880			

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F 880	Continued From page 33 gloves was required when cares or transfers were completed for residents with a wound or catheter. On 10/15/24 at 10:54 a.m., LPN-A, known as the nurse manager, confirmed R136 was on EBP due to a wound on his coccyx, and stated staff were expected to wear gown and gloves during high contact care including transfers, brief changes, and dressing. LPN-A further stated staff were expected to change gloves after old dressing was removed, wash hands and place new gloves. On 10/15/24 at 11:21 a.m., NA-C confirmed R136 was in EBP and stated a gown was not worn during morning cares for R136, and stated a gown and gloves were expected to be worn for residents on EBP. On 10/15/24 at 12:45 p.m., during an interview the director of nursing (DON) confirmed R136 was on EBP and stated staff were not expected to wear gown and gloves when a resident on EBP during transfers. DON was observed to read the EBP signs that were posted on EBP residents doors. After the DON reviewed the EBP precautions, the DON stated for EBP, staff should wear gowns and gloves for all high contact resident care activities and not just with cares related to the reason for being on EBP. The DON further stated staff were not trained to wear gown and gloves during transfers for residents on EBP. The DON further stated, during a dressing change staff were expected to remove gloves, complete hand hygiene, and get new gloves prior to the clean dressing applied. On 10/15/24 at 3:35 p.m., registered nurse (RN)-C stated she was the infection preventionist at the facility and stated staff were expected to	F 880			

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F 880	Continued From page 34 wear gown and gloves when providing cares and transfers for resident with EBP. RN-C stated staff were expected to change gloves and wash hands during wound care when the old dressing was removed. Facility policy Enhanced Barrier Precautions dated 4/1/24, indicated All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. All staff receive training in high-risk activities and common organisms that require enhanced barrier precautions. Implement enhanced barrier precautions for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheotomy/ventilator tubes. h. Wound care: any skin opening requiring a dressing. Enhanced barrier precautions should be followed outside the resident ' s room when performing transfers and assisting during a high contact activity such as bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with	F 880			

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F 880	Continued From page 35 transfers and mobility, or any high-contact activity. Facility Policy titled Wound Care Treatment procedure dated 2/24, indicated Steps to complete addressing change: Prior to starting, wash your hands and prepare the dressing supplies in an established clean field. Apply clean gloves Remove the previous dressing Dispose of previous dressing and designated container Remove your gloves and complete hand hygiene Evaluate the wound Clean the wound Remove gloves dispose of them in the designated container and complete hand hygiene Apply clean gloves and complete dressing change while following the provider's order When the treatment is completed remove your gloves dispose of any additional items and complete hand hygiene	F 880			
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 881	How corrective action will be		11/22/24

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F 881	Continued From page 36 facility failed to implement a process for antibiotic review to determine the efficacy and resident outcomes (appropriate medication, dose, and duration) for 4 of 4 residents R12, R27, R1, and R31 reviewed. Further, this had the potential to affect all 34 residents living in the facility. Findings include: R12's Face Sheet dated 5/4/23, included diagnoses of quadriplegia, neurogenic bowel, and neuromuscular dysfunction of the bladder. R12's care plan dated 8/6/24, indicated R12 will be free from signs/symptoms of urinary tract infection (UTI). Interventions included morning bowel program, assistance with peri-care in the morning, bedtime, and as needed, provided incontinence products, monitored for signs/symptoms of UTI, monitored suprapubic catheter output, change the suprapubic catheter per physician orders, and suprapubic catheter care per facility policy. The facility's Monthly Resident Infection Statistics documentation for the month of August 2024, indicated R12 was treated for a catheter associated urinary tract infection (CAUTI). R12 was prescribed ciprofloxacin 250 mg two times per day for five days. No outcome/s was documented on the facility's Monthly Resident Infection Statistics log to determine the efficacy of R12's treatment plan. R27's Face Sheet dated 2/12/24, included diagnoses of a nondisplaced intertrochanteric fracture of the right femur, type 2 diabetes, dementia, and weakness.	F 881	accomplished for those residents found to have been affected by the deficient practice¿ Facility infection tracking log was reviewed, resident outcomes were determined, and infection tracking log was updated for R12, R27, R1, and R31. 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¿ Reviewed Monarch's Antibiotic Stewardship policy. Education provided to facility Infection Preventionist on the process for antibiotic review to ensure documentation of antibiotic efficacy and resident outcomes. An audit was completed on all residents to ensure appropriate documentation was in place. 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 facility infection tracking to ensure appropriate completion and documentation of antibiotic review for efficacy and resident outcome. Audits will		

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F 881	Continued From page 37 R27's care plan dated 9/9/24, indicated R27 was at risk for altered elimination related to mobility and recurrent UTI's. Interventions included assistance with peri-care in the morning, bedtime, and as needed, incontinence products were to be provided as needed, monitor for signs/symptoms of UTI and report suspected signs/symptoms of UTI. The facility Monthly Resident Infection Statistics documentation for the month of July 2024, indicated R27 was treated on two separate dates (7/5/24 and 7/17/24) for UTI. On 7/5/24, R27 was prescribed Macrobid capsule 100 mg two times per day for five days. On 7/7/24, the antibiotic was changed to Keflex due to aggressive behavior related to antibiotics. No outcome/s was documented on the facility Monthly Resident Infection Statistics log to determine the efficacy of R27's treatment plan. R1's Face Sheet dated 5/8/2, included diagnoses of type 2 diabetes, chronic kidney disease stage 3, and urinary tract infection. R1's care plan dated 10/8/24, indicated R1 had functional bowel and bladder incontinence related to persistent mood, hemiplegia, cerebrovascular accident (CVA), obesity, and frequently incontinent of urine and stool. Interventions included assistance to the bathroom before and after meals, at bedtime, as needed, and to wear incontinence pads. The facility Monthly Resident Infection Statistics for June and August 2024, indicated R1 was treated for a UTI once in June and once in August. On 6/15/24, R1 was prescribed cefadroxil 500 mg two times per day for five days. On	F 881	be completed weekly x4, monthly x2, and reviewed with QAPI committee for further review and recommendations.		

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F 881	Continued From page 38 8/28/24, R1 was prescribed amoxicillin-pot clavulanate (Augmentin) tablets 875/125 mg two times per day for seven days. On 8/3/24, R1 was treated for pneumonia and acute cystitis and prescribed azithromycin 250 mg tablets daily for four days and cefuroxime tablets 500 mg two times per day for seven days. On 9/5/24, R1 was treated for sepsis of an unclear source and prescribed Augmentin 875/125 mg two times per day. No outcome/s was documented to determine the efficacy of R1's treatment plan for above noted infections. R31's Face Sheet dated 4/9/24, included a diagnosis of cough. R31's care plan dated 9/5/24, had no focus areas and/or interventions for R31's cough. Interventions indicated on the facility monthly resident infection statistics included a chest x-ray on 6/18/24. R31 was prescribed azithromycin 500 mg once, then 250 mg daily for five days. No outcome/s was documented to determine the efficacy of R31's treatment plan for upper respiratory infection (URI). On 10/15/24 at 2:03 p.m., during interview with the infection preventionist and director of nursing (DON), the facility's Monthly Resident Infection Statistics log documentation for 6/2024 to 9/2024, was reviewed for infection prevention and control. The documentation for 6/2024 to 9/2024, lacked documented outcomes for R12, R27, R1, and R31 including susceptibility, signs/symptoms of infection, any prolonged treatment, side effects, and/or change in antibiotic. After review of the documentation, the infection preventionist and DON acknowledged no resident outcomes were documented and stated that the resident	F 881			

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F 881	Continued From page 39 outcomes needs to be documented when residents are prescribed antibiotics for appropriate antibiotic stewardship. Further, the infection preventionist stated it's expected that nursing monitored signs/symptoms of infection, monitored vital signs, followed the care plan, and notified the provider and family with the resident's condition. On 10/15/24 at 12:26 p.m., during a telephone call, the consulting pharmacist (CP)-A stated the facility was expected to complete timely and address urine culture results and follow up with the provider regarding UC results. CP-A stated failure to address or follow up with the provider regarding urine culture results can lead to ineffective treatment, specifically, if the prescribed medication is not susceptible with the culture results, it may exacerbate the infection or prolong treatment. The facility Antibiotic Stewardship policy revised on 3/13/23, indicated: 1. The medical director, consultant pharmacist, DON, and infection preventionist will be responsible for promoting and overseeing antibiotic stewardship activities in the facility. 2. Tracking- the infection preventionist, along with the consultant pharmacist, will monitor antibiotic use by utilizing a facility approved infection/antibiotic surveillance tracking form and thru monthly medication reviews. The information gathered will include resident name, unit and room number, date symptoms appeared, name of antibiotic, start date of antibiotic, pathogen identified, site of infection, date of culture, stop date, total days of therapy, outcome, and adverse events if applicable. 3. Reporting- the infection preventionist and the			F 881			

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F 881	Continued From page 40 pharmacy consultant will provide regular feedback on antibiotic use and outcomes to the facility staff and the QAPI committee.	F 881			

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K 000	INITIAL COMMENTS An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/16/2024. At the time of this survey, Bayside Manor, LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division	K 000			

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

Electronically Signed

TITLE

(X6) DATE

11/13/2024

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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K 000	Continued From page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Bayside Manor LLC was constructed in 1974, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. In 2008, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. There are hardwire/battery back up smoke alarms in	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245473	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER BAYSIDE MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 640 THIRD STREET GAYLORD, MN 55334		
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K 000	Continued From page 2 resident rooms that are interconnected to the nurse call system in the 2008 addition. The facility has a capacity of 44 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 132 SS=F	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their 2-hour fire separation wall per NFPA 101 (2012 edition), Life Safety Code, sections 19.1.3.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 132	2-hour fire separation walls between assisted living and long-term care facility, between memory care facility and long-term care facility, and between clinic facility and long-term care facility will be repaired. In addition, the 2-hour fire separation wall systems throughout the entire facility will be inspected on both	11/22/24	

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K 132	Continued From page 3 On 10/16/2024, between 9:45 AM and 1:45 PM, it was revealed by observation that there were open penetrations in the 2-hour fire separation walls at the following locations: 1. Between assisted living facility and long-term care facility, 2. Between memory care facility and long-term care facility, 3. Between clinic facility and long-term care facility, NOTE: Check the entire facility 2-hour fire separation wall system on both sides for this deficiency. An interview with Maintenance Director and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 132	sides. Current residents residing at the facility have the potential to be affected by this deficiency. Re-education regarding smoke barrier requirements will be initiated with applicable staff. Administrator or designee audits monthly x 3. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months. Corrective action will be completed by 11/22/2024.		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For	K 914		11/22/24	

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K 914	Continued From page 4 LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 10/16/2024, between 9:45 AM and 1:45 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing that the facility has properly tested all electrical receptacles in the resident rooms. An interview with the Maintenance Director, Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 914	Electrical testing and maintenance will be completed for all electrical receptacles in the resident rooms. Current residents residing at the facility have the potential to be affected by this. Re-education regarding the testing/maintenance requirements of electrical receptacles will be initiated with applicable staff. Administrator or designee audits monthly x 3. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months. Corrective action will be completed by 11/22/2024.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 4, 2024

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

Re: State Nursing Home Licensing Orders
Event ID: Z7BT11

Dear Administrator:

The above facility was surveyed on October 13, 2024 through October 15, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2024
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/13/24-10/15/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

11/12/24

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H54739391C (MN00106453) and H54739392C (MN00101186). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000			

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 1 resident (R5) reviewed for hospice. Findings include: R5's Face Sheet dated 10/15/24, indicated R5 primary payer was hospice, care providers included hospice, and diagnoses hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (conditions that cause weakness or paralysis on one side of the body after a stroke), dementia, and altered mental status. R5's significant change in status MDS dated	2 550	Corrected	11/22/24	

Minnesota Department of Health

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2 550	Continued From page 3 9/17/24, section O, K1 under special treatments and programs, did not include hospice care services . Section J 1400 Prognosis: conditions or chronic diseases that may result in a life expectancy of less than 6 months indicated no. R5's hospice plan of care printed 10/15/24, indicated R5's hospice start of service date was 9/11/24. R5's care plan dated 10/13/24, indicated hospice Cares r/t (related to) end stage kidney disease, enrolled for services with hospice. On 10/15/24 at 11:49 a.m., registered nurse (RN)-A, also identified as MDS specialist, indicated R5 was admitted to the facility on hospice. Upon review of admission MDS, RN-A confirmed section 0 was not coded as R5 receiving hospice services. On 10/15/24 at 12:37 p.m., the director of nursing (DON) stated the MDS should have been completed accurately and hospice services should have been indicated on the admission MDS. On 10/15/24 at 2:54 p.m., the administrator stated the facility followed the RAI (resident assessment instrument) Manual and doesn't utilize a specific MDS policy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee or resident assessment instrument (RAI) coordinator could review the RAI manual, review policies and procedures to ensure accurate coding of the MDS. The DON, designee or RAI coordinator could then perform audits to ensure compliance. The results of those audits could be taken to	2 550			

Minnesota Department of Health

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2 550	Continued From page 4 Quality Assurance Performance Improvement (QAPI) committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a comprehensive reassessment after a fall incident and ensure new interventions were implemented to prevent further falls for 1 of 1 resident (R11) reviewed for falls. Findings include: R11's admission record printed 10/15/24, indicated diagnoses of chronic obstructive pulmonary disease (a lung disorder), muscle	2 830	Corrected	11/22/24	

Minnesota Department of Health

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2 830	Continued From page 5 weakness, and history of falling. R11's admission Minimum Data Set (MDS) dated 9/27/24, indicated severe cognitive impairment, no rejection of care, use of a wheelchair for mobility, substantial assistance with transfers, and fall history prior to admission. R11's facility Kardex printed 10/14/24, indicated independent with toileting, assist of one staff with bathing, shaving, dressing, and bed mobility, assistance of one staff, walker, and gait belt for walking, and safety intervention of gripper socks at bedtime. R11's care plan dated 10/11/24, listed focus area of fall risk related to COPD, epilepsy, muscle weakness, and history of falls. Interventions included gripper socks or shoes to feet when not in bed and follow PT and OT instructions for mobility function. R11's progress note dated 9/28/24, listed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. R11's progress note dated 9/29/24, indicated R11 attempted to self-transfer to the bathroom from his bed and had a fall. Staff educated R11 on call light use and waiting for assistance. R11 had a skin tear to right knee from the fall. A facility incident review and analysis dated 9/29/24, was started but not comprehensively completed. The incident review and analysis lacked review of the fall to determine cause and intervention to prevent future falls. In addition, no new intervention was identified on the care plan. A facility incident note dated 10/11/24, indicated	2 830			

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2 830	Continued From page 6 R11 had an additional fall on 10/11/24 at 4:25 a.m., when found on the floor next to his bed after attempting to walk to the bathroom independently. An incident review and analysis was completed after this fall and intervention including gripper socks when out of bed. During observation on 10/13/24 at 1:16 p.m. and 2:33 p.m., R11 was observed walking in the hall without walker or staff assistance. During interview on 10/14/24 at 9:40 a.m., nursing assistant (NA)-B indicated she was not aware of what interventions were in place for R11 other than having him wear gripper socks. During interview on 10/15/24 at 10:00 a.m., licensed practical nurse (LPN)-A stated no comprehensive fall assessment had been completed after R11's fall on 9/29/24. LPN-A further stated an interdisciplinary team (IDT) risk assessment meeting was held on 9/30/24 and R11's fall was reviewed with suggested intervention of leaving R11's walker next to his bedside. LPN-A confirmed the intervention was discussed at the meeting but a fall assessment had not been completed and the intervention had not been implemented or added to the care plan. LPN-A stated without the intervention on the care plan staff would not be able to see it on their Kardex tool and would not know the intervention had been put in place. During interview on 10/15/24 at 12:28 p.m., director of nursing (DON) stated she would expect a post fall assessment done within 48 hours of a fall and an intervention be put in place immediately, reviewed at the next facility risk management meeting, and then placed on the care plan. DON confirmed R11's fall dated	2 830			

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2 830	Continued From page 7 9/29/24, was discussed at the facility risk management meeting and an intervention of leaving R11's walker at bedside was discussed but had not been implemented. DON further stated timely implementation of interventions was important for reducing fall risk for residents. Facility policy Fall Prevention and Management updated 2/2024, indicated the following; Assessing and Evaluating Falls and Causal Factors When a fall occurs: Nursing staff will complete an incident review and analysis. Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and minimize complications from falling. Staff may implement relevant interventions to try to minimize serious consequences of falling and monitor and document each resident's response to interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. DON or designee could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			

Minnesota Department of Health

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2 840	Continued From page 8	2 840			
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be	2 840			11/22/24

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2 840	Continued From page 9 completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow provider's order of catheter flush for 1 of 1 resident (R12) reviewed with indwelling catheter to minimize the risk for urinary tract infections (UTI). Additionally the facility failed address urinalysis (test of the urine to detect infection) results for 2 of 2 residents (R5 and R12) reviewed for UTI. Findings include: R5's significant change Minimum Data Set (MDS) dated 9/17/24, indicated R5 was dependent on staff for toileting hygiene, toilet transfer, and utilized a wheelchair, frequently incontinent of urine, taking an antibiotic, diagnoses included: chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (conditions that cause weakness or paralysis on one side of the body after a stroke), dementia, and altered mental status R5's care plan dated 10/13/24, indicated alteration in elimination r/t (related to) dx (diagnosis) of urinary incontinence, will be free from signs/symptoms of UTI, obtain/review labs per MD (medical doctor) order R5's progress note dated 9/10/24 at 3:09 p.m., the director or nursing (DON) indicated R5	2 840	Corrected		

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2 840	Continued From page 10 returned from hospital and does have a UTI, antibiotics initiated. R5's progress note dated 9/10/24 at 5:24 p.m., registered nurse (RN)-B indicated R5 returned from the hospital with an order for cefdinir (antibiotic used to treat infections) 300 mg bid (twice a day) for 7 days due to a UTI. Family aware. Order faxed to pharmacy. R5's document transfer report dated 9/10/24, emergency provider notes dated 9/10/24, indicated R5 urinalysis consistent with UTI, will plan to discharge back to facility with prescription for cefdinir pending urine culture. R5's urine culture results with a fax dated 9/24/24, to the facility indicated R5's urine culture results. The document did not list the the current antibiotic, cefdinir, R5 was prescribed. R5's record review failed to indicated R5's urine culture results were addressed by the facility. On 10/15/24 at 11:11 a.m., licensed practical nurse (LPN)-A, known as the nurse manager, stated the urine culture result was scanned into electronic medical record (EMR) without the nurse reviewing the result. LPN-A stated the results are dated and signed by the nurse when reviewed. LPN-A stated health information was expected to make sure documents were signed and dated by a nurse prior to scanned into the EMR to ensure results were addressed. LPN-A confirmed R5's UC result dated 9/10/24, and faxed to the facility 9/23/24, was not reviewed by a nurse as expected and was important to ensure R5 was on the correct antibiotic for her UTI. On 10/15/24 at 12:26 p.m., during a telephone	2 840			

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2 840	Continued From page 11 call consulting pharmacist stated the facility was expected to timely review and address urine culture results and follow up with the provider regarding UC results. CP-A stated failure to address or follow up with the provider regarding urine culture results can lead to ineffective treatment, specifically, if the prescribed medication is not susceptible with the culture results, it may exacerbate the infection or prolong treatment. On 10/15/24 at 12:37 p.m., the DON, stated the nurse manager were expected to be aware of residents who had a UC pending and confirmed there was a "breakdown" in the process. The DON further stated HIM was not expected to scan documents in the EMR until signed and dated by nursing. On 10/15/24 at 1:33 p.m., health information management (HIM)-D stated she scanned documents in the EMR, and confirmed the documents were expected signed and dated prior to scanned into the EMR. HIM-D stated documents not signed or dated by nursing were expected brought back to nursing to ensure the document or order was reviewed and entered. HIM-D stated UA's and UC's results were also expected signed and dated prior to scanned into the EMR. HIM-D confirmed documents were scanned into the EMR without nurse signature or date and the facility had provided education ensuring nursing had reviewed prior to her scanning into the EMR. R12's quarterly MDS dated 8/7/24, indicated R12 was cognitively intact, had an indwelling urinary catheter, dependent on staff for toileting hygiene and toilet transfers, utilized a wheelchair, diagnoses included traumatic spinal cord	2 840			

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2 840	Continued From page 12 dysfunction, neurogenic bladder (a condition that affects bladder control due to nerve damage or brain disorders), and quadriplegia (paralysis that affects all of a person's limbs). R12's physician orders start date 6/26/24, indicated flush and irrigate catheter every other day with 60 cc (cubic centimeter) normal saline for oliguria (low urine output) and progress note needed at 8:00 p.m. R12's treatment administration record (TAR) dated 9/1/24-9/30/24, indicated the provider order flush and irrigate catheter every other day with 60 cc normal saline for oliguria and progress note needed scheduled at 8:00 p.m., was completed 10 out of the 15 times, and was not completed five times. R12's progress note dated 9/27/24 at 6:13 a.m., licensed practical nurse (LPN)-B indicated R12 was bypassing her catheter catheter, nurse flushed her catheter at that time, there was 250 cc out at the time she flushed it. R12's progress note dated 9/28/24 at 5:37 a.m., LPN-B indicated R12's brief was wet, nurse flushed her catheter and emptied her bag to ensure that it was following [flowing] properly, catheter has sediment that was clogging it. R12's progress note dated 10/3/24 at 3:53 a.m., LPN-B indicated R12 requested for her catheter flushed because she could feel it bypassing, nurse flushed it and had CNA's apply a brief. R12's progress note dated 10/7/24 at 4:30 a.m., LPN-B indicated R12 was having trouble with her catheter, R12 indicated her catheter had been clogged for a while and they had to change her	2 840			

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2 840	Continued From page 13 brief a total of six times, nurse attempted to flush her catheter without any success, there was so much sediment that the water was not going through. Nurse then proceeded to change her catheter, it is currently patent, she had 700 cc's out. Nurse sent an email to the provider requesting an order for UA/UC, her urine is dark, odorous, and full of sediment. The lat time time it was changed was eight days ago, she is to have it changed every 14 days , but it has not been lasting that long. R12's progress note dated 10/9/24 at 5:33 a.m., LPN-B indicated nurse applied a new catheter bag and collected a UA, urine dark with slight odor, a lot of sediment, urine sample in the refrigerator, waiting for it to be sent to lab. R12's progress note dated 10/11/24 at 1:45 p.m., LPN-A indicated writer collected UA and sent over with order to pharmacy, awaiting results. R12's progress note dated 10/12/24 at 12:54 a.m., LPN-B indicated received the UA results from lab department, the following results were abnormal; urine appearance was turbid (murky or unclear, instead of its normal clear or slightly cloudy appearance), urine ph is higher than 9 (normal urine pH ranges from 4.6 to 8.0), urine leukocyte esterase 3 (sign of infection), urine protein 3 (can be a sign of kidney problems), urine blood 2 (sign of infection), results faxed to provider waiting for response. On 10/13/24 at 6:16 p.m., R12 was seated in her motorized wheelchair in her room with family member (FM)-E. R12 stated she had problems with her urine and clogging of the catheter tubing within the last month. R12 stated staff were supposed to flush the catheter every other day so	2 840			

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2 840	Continued From page 14 sediment does not build up in the catheter tubing. R12 stated the staff do not routinely flush the catheter tubing every other day. R12 stated she had in the last month problems with the catheter not flowing properly due to the sediment built up and was urine was leaking around the catheter and she had to wear a brief due to the urine leaking from the catheter. R12 stated she had a recent urine collection to see if she had an infection and stated she must not because she had not heard from the staff. R12 stated the urine test was due to the smell, dark color, and lots of sediment in the urine. FM-E stated R12 had never had a UTI prior to her admission the facility. On 10/15/24 at 9:59 a.m., physician assistant (PA)-H stated he was R12's medical provider and comes to the facility once a week. PA-H stated the facility was expected to fax UA results on the weekend to the on call provider and was not aware of any pending UA results for R12. PA-H stated the staff were expected to follow the order and flush R12's catheter every other day. PA-H stated not flushing the catheter every other day could cause sediment to build up and could cause a UTI. PA-H stated staff were expected to follow up with the provider within 24 hours if a provider had not addressed a residents UA results. On 10/15/24 at 10:56 a.m., LPN-A, known as the nurse manager stated R12 was known to have sediment build up in her catheter. LPN-A stated she was not aware staff were not flushing R12's catheter as ordered every other day, and would expect staff follow provider orders LPN-A was observed to check the EMR for R12 and confirmed there were five dates in September when R12's catheter was not flushed as ordered. LPN-A stated R12 had problems with her catheter	2 840			

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2 840	Continued From page 15 not flowing and her catheter leaking and R12 had to wear a brief. LPN-A stated R12's catheter not flushed could cause sediment to build up. LPN-A further stated a UA was cooled on 10/11/24, and the results were faxed to the provider on 10/13/24, and confirmed the UA result had not been addressed by the provider, LPN-A further stated the facility was responsible to follow up within 24 hours if a result was not addressed by the provider. On 10/15/24 at 12:53 p.m., the DON stated staff were expected to follow provider orders and flush R12's catheter every other day. The DON stated nurse managers were expected to run a daily report that indicates residents missed orders. The DON was observed to run report on the EMR and confirmed R12 had missed catheter flushes in September. The DON stated the catheter flushes were important so sediment does not build up and could cause a UTI. The DON stated she has educated facility staff all orders were expected completed prior to staff leaving their shift. Further, the DON stated R12's UA result from 10/13/24 was expected to be addressed by the provider and if not addressed would expect the nurse manager to reach out the provider within 24 hours. Policy on UA/UC results was requested and not received. Facility policy Infection Prevention and Control Program dated 3/13/23, indicated : The infection prevention and control committee is responsible for reviewing and providing feedback on the overall program. s surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may	2 840			

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2 840	Continued From page 16 include: a. whether physician management of infections is optimal; b. whether antibiotic usage patterns need to be changed because of the development of resistant strains; c. whether information about culture results or antibiotic resistance is transmitted accurately and in a timely fashion; and d. whether there is appropriate follow-up of acute infections Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. 2. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies are reviewed, revised as necessary, staff are trained and monitored to assure all residents with an indwelling urinary catheter receive nursing care and treatment, based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840			
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact	21134			11/22/24

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21134	Continued From page 17 surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwasher chemical sanitization solution was monitored to ensure dishes were properly sanitized. This had the potential to affect all 34 residents who resided in the facility. Findings include: During an observation and interview on 10/15/24, at 10:05 a.m., observed CSA-B test the chemical sanitizing solution at the dishwasher using a chlorine test strip. The dishwasher had been in use immediately prior to this. The test strip measured 25 parts per million (PPM). CSA-B was asked to run another load and test it again. Again, it measured 25 ppm. According to facility policy, the chemical solution should test at 50-100 ppm. The culinary services director (CSD)-F was requested to test the solution, which also tested at 25 ppm. CSD-F stated he would contact the dishwasher vendor. CSD-F stated he did not do periodic spot checks to ensure staff were performing testing properly and according to policy. CSD-F stated staff received training for testing the sanitizing solution upon hire, but he didn't document the content of the training, or when the training occurred. The water temperature on the dishwasher read 120 degrees Fahrenheit (F) which was correct according to regulation, but both CSA-B and CSD-F thought	21134	Corrected		

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21134	Continued From page 18 the temperature needed to be 150 degrees F. A paper log titled Dishwashing Record Low Temperature/Chemical posted on the wall by the dishwasher indicated for the month of October, three times a day, all ppm were read as 50 ppm and all but three water temperatures read as 150 degrees F. The log for September indicated the same. The log for August indicated ppm ranging from 10 to 50 ppm and temperatures ranging from 83 to 150 degrees F. During a telephone interview on 10/15/24, at 3:28 p.m., vendor representative (VR)-G for the dishwasher stated the facility utilized a low temperature unit. VR-G stated the water temperature should be set at 120 degrees F, and the chemical sanitizing solution should test between 50-100 ppm. While talking to VR-G, CSD-F came to the conference room and stated the test strips were "darker" now, but still not up to 50 ppm. Over speaker phone, VR-G advised CSD-F to switch to paper products until the dishwasher unit could be serviced, which CSD-F stated had been arranged for on 10/16/24. Facility Dishwashing Machine Use policy dated 2001, indicated food service staff required to operate the dishwashing machine would be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. A supervisor would check the dishwashing machine for proper concentrations of sanitizer solution (measured as parts-per-million [PPM] or mL/L) after filling the dishwashing machine and once a week thereafter. Concentrations would be recorded on a facility approved log. Corrective action would be taken immediately if sanitizer concentrations were too low. The operator would check temperatures using the machine gauge	21134			

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21134	Continued From page 19 with each dishwashing machine cycle and would record the results on a facility approved log. The operator would monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures would be reported to the supervisor and corrected immediately. If hot water temperatures or chemical sanitation concentrations did not meet requirements, the dishwashing machine would cease immediately until temperatures or PPM were adjusted. Type of Solution: chlorine, and minimum concentration 50-100 ppm. SUGGESTED METHOD OF CORRECTION: The dietary manager could develop and implement policy and procedure to ensure all staff have been educated, are following regulatory requirements, and are monitoring dishmachine sanitation requirements. Audits could be conducted to ensure compliance and results brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21134			
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385			11/22/24

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21385	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure personal protective equipment (PPE) was utilized for 1 of 2 residents (R136) reviewed for enhanced barrier precautions (EBP). Additionally, the facility failed to ensure proper glove use and hand hygiene was performed during wound care for 1 of 3 residents (R136) reviewed for pressure ulcers. Finding include: R136's admission Minimum Data Set (MDS) dated 10/3/24, indicated no cognitive impairment, one stage two pressure ulcer present on admission, two unstageable pressure ulcers present on admission, and diagnosis included stage two pressure ulcer of sacral region. R136's care plan printed 10/15/24, indicated R136 was on enhanced barrier precautions due to wound to coccyx requiring treatment and interventions included: staff to follow enhanced barrier precautions, use appropriate communication to follow EBP, explain reason for use of enhanced barrier precautions, staff to don/doff PPE per enhanced barrier precautions when providing high contact cares; admitted with ulcer on coccyx from prior facility and redness to right heel and interventions included: treatment to open areas per order, weekly measurements and assessment of wound. On 10/14/24 at 8:48 a.m., a sign was observed on R136's door and indicated Enhanced Barrier Precautions, ... providers and staff must wear gloves and gown for the followingtransferring, providing hygiene, wound care. A cart outside of R136's room was observed with PPE and	21385	Corrected		

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21385	Continued From page 21 included gowns and gloves. Trained medication aide (TMA)-A and nursing assistant (NA)-B entered R136's room and failed to don PPE, and were observed to use a mechanical lift to transfer R136 from the wheelchair to the bathroom. TMA-A and NA-B used bare hands to move R136's feet from the wheelchair onto the mechanical lift and NA-B was observed to pull down R136's brief with ungloved hands. On 10/14/24 at 1:17 p.m. TMA-A confirmed no PPE was worn during the transfer of R136 earlier in the day. TMA-A stated gown and gloves were expected to be worn during transfers for residents placed on EBP. On 10/15/24 at 7:37 a.m., NA-C entered R136's room and put on gloves and assisted R136 with removing his shirt and washed R136's upper body with gloved hands and no gown. NA-C further was observed to remove R136's pants and removed the fastening tabs from R136's brief and washed R136's peri area with gloved hands and no gown. R136's coccyx had a dressing cover the pressure area. On 10/15/24 at 8:15 a.m., licensed practical nurse (LPN)-C entered R136's room with gloves, gown, and wound care supplies. NA-C (with gloved hands and no gown) and LPN-C turned R136 to his right side in bed. LPN-A with gloved hands, removed the old dressing from R136's buttock, sprayed the wound with wound cleanser, used same gloved hands and opened a gauze package and used the gauze to dab the wound. NA-C (gloved not gowned), assisted LPN-C and again rolled R136 side to side and R136's brief was removed. LPN-C sprayed the wound again, measured the wound, and applied cream with same gloved hands, opened a clean dressing and	21385			

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21385	Continued From page 22 placed the dressing on the wound, then applied skin prep around the wound . LPN-C further opened another dressing with same gloved hands and placed the dressing on the buttocks area, and then grabbed a clean brief and with assistance of NA-C a new brief was placed on R136. LPN-C removed gloves and placed in the trash and removed gown and exited R136's room. On 10/15/24 at 8:24 a.m., LPN-A confirmed gloves were not changed during R136's wound care and stated he was expected to change gloves and complete hand hygiene after removing the old dressing and place new clean gloves on prior to applying the new dressing. LPN-A stated gown and gloves were expected during wound care, however was not sure if staff had to wear PPE if they were not completing wound care and were assisting with the transfer. LPN-A proceeded to read the sign on R136's door and stated after reading the sign staff were expected to wear gown and gloves with transfers, hygiene, and dressing the resident with EBP. On 10/15/24 at 8:26 a.m., NA-B confirmed gloves or gown was not worn when she toileted or transferred R136. NA-B stated the facility had not provided education that PPE including gown and gloves was required when cares or transfers were completed for residents with a wound or catheter. On 10/15/24 at 10:54 a.m., LPN-A, known as the nurse manager, confirmed R136 was on EBP due to a wound on his coccyx, and stated staff were expected to wear gown and gloves during high contact care including transfers, brief changes, and dressing. LPN-A further stated staff were expected to change gloves after old dressing was removed, wash hands and place new gloves.	21385			

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21385	Continued From page 23 On 10/15/24 at 11:21 a.m., NA-C confirmed R136 was in EBP and stated a gown was not worn during morning cares for R136, and stated a gown and gloves were expected to be worn for residents on EBP. On 10/15/24 at 12:45 p.m., during an interview the director of nursing (DON) confirmed R136 was on EBP and stated staff were not expected to wear gown and gloves when a resident on EBP during transfers. DON was observed to read the EBP signs that were posted on EBP residents doors. After the DON reviewed the EBP precautions, the DON stated for EBP, staff should wear gowns and gloves for all high contact resident care activities and not just with cares related to the reason for being on EBP. The DON further stated staff were not trained to wear gown and gloves during transfers for residents on EBP . The DON further stated, during a dressing change staff were expected to remove gloves, complete hand hygiene, and get new gloves prior to the clean dressing applied . On 10/15/24 at 3:35 p.m., registered nurse (RN)-C stated she was the infection preventionist at the facility and stated staff were expected to wear gown and gloves when providing cares and transfers for resident with EBP. RN-C stated staff were expected to change gloves and wash hands during wound care when the old dressing was removed. Facility policy Enhanced Barrier Precautions dated 4/1/24, indicated All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions.	21385			

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21385	Continued From page 24 All staff receive training in high-risk activities and common organisms that require enhanced barrier precautions. Implement enhanced barrier precautions for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheotomy/ventilator tubes. h. Wound care: any skin opening requiring a dressing. Enhanced barrier precautions should be followed outside the resident ' s room when performing transfers and assisting during a high contact activity such as bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activity. Facility Policy titled Wound Care Treatment procedure dated 2/24, indicated Steps to complete addressing change: Prior to starting, wash your hands and prepare the dressing supplies in an established clean field. Apply clean gloves Remove the previous dressing Dispose of previous dressing and designated container	21385			

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21385	Continued From page 25 Remove your gloves and complete hand hygiene Evaluate the wound Clean the wound Remove gloves dispose of them in the designated container and complete hand hygiene Apply clean gloves and complete dressing change while following the provider's order When the treatment is completed remove your gloves dispose of any additional items and complete hand hygiene SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections (EBP). The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992.	21530			11/22/24

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21530	Continued From page 26 This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the provider's response to the monthly medication review was followed for 1 of 5 (R18) residents reviewed for unnecessary medications. Findings include:	21530	Corrected		

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21530	Continued From page 27 R15's quarterly Minimum Data Set (MDS) dated 9/11/24, indicated R15 had moderate cognitive impairment, diagnosis included diabetes mellitus, and received insulin injections. R15's consultant pharmacist (CP)-A recommendation to physician dated 9/10/24, indicated consider redrawing A1C (measures your average blood sugar levels over the past three month) and adjusting insulin doses as needed. The provider responded to the recommendation on 9/17/24, and ordered A1C. R15's provider and nursing orders were reviewed and lacked documentation the facility had completed the physician ordered A1C. On 10/15/24 at 7:28 a.m., licensed practical nurse (LPN)-A confirmed R15's physician ordered A1C was not addressed by nursing staff as expected. LPN-A stated the order for the A1C was not sent to nursing before the order was scanned into the electronic medical record (EMR) by health information management (HIM)-A. LPN-A stated HIM-A was expected to make sure documents including orders were signed and dated by a nurse prior to scanned into the EMR to ensure orders were addressed. On 10/15/24 at 12:51 p.m., the director of nursing (DON) stated the pharmacist emailed the nurse managers with the provider recommendations, and stated the nurse managers were responsible to follow up with the pharmacy recommendations and provider response. The DON stated she would expect HIM to bring the order back to nursing if the order was not signed and dated by	21530			

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21530	Continued From page 28 nursing. The DON stated she would expect the order for 9/17/24, addressed and completed. A facility policy was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and pharmacist or their designee, could develop and implement policies/procedures and staff training related to assurance that consulting pharmacist recommendations are acted upon adequately. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530			
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rights and choices were protected for 1 of 1 resident (R16) when his recliner was removed from his room against his wishes. Findings include: R16's admission Minimum Data Set (MDS) dated	21805	Corrected		11/22/24

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21805	Continued From page 29 7/9/24, indicated an admission date of 7/3/24, intact cognition, no rejection of care, and diagnoses of heart failure, kidney failure, and edema. R16's care plan dated 7/9/24, focus area titled cognition indicated R16 was at risk for alteration in cognition related to adjustment to placement with interventions listed as allow resident time to communicate his needs/wants, provide and maintain consistent environment. R16's Physician's orders dated 7/2/24, indicated elevating legs to the level of the heart or above for 45-60 minutes, pump ankles while sitting in chair, elevate foot of bed, prop feet up on a pillow when sitting in recliner every shift. R16's Behavior note dated 7/4/24 at 3:37 a.m., indicated R16 was annoyed with staff due to not having his (personal) recliner at the facility yet from his prior facility. Notes further indicated R16 stated he slept in his chair, couldn't sleep in a bed, and needed his chair by that night. R16's New Admission Note dated 7/5/24 at 3:38 a.m., indicated R16 had a hard time falling asleep that night because he was upset about not having his recliner from his prior facility. R16's New Admission Note dated 7/6/24 at 4:58 a.m., indicated R16's recliner had arrived from his prior facility, he was very happy to have his recliner since being without it since admission on 7/3/24, and was resting quietly in his recliner with his eyes closed. R16's Health Status progress note dated 9/15/24 at 3:37 a.m., indicated R16 rested well throughout the night and slept in his recliner with legs	21805			

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21805	Continued From page 30 elevated for comfort. During interview on 10/14/24 at 8:31 a.m., R16 stated his recliner was taken from his room several days ago to be cleaned and he was unsure when it would be returned. R16 further stated he slept in his recliner every night and had been sleeping in his wheelchair since his recliner was removed. R16 stated he wanted to put his feet up but could not due to his recliner being gone. R16 further stated he did not sleep in his bed due to it being too small and uncomfortable. During interview on 10/14/24 at 2:03 p.m., R16 stated he did not give permission for his chair to be taken, he had asked for a sheet to be put over it instead, he was sick of sleeping in his wheelchair, and he wanted his chair back by evening. During observations from 10/13/24 through 10/15/24, R16 was observed in his wheelchair with his legs down on footrests. His personal recliner was absent from his room. An alternate recliner from the facility common area was provided after 5 p.m. on 10/14/24. R16's personal recliner was returned on 10/15/24. During interview on 10/14/24 at 2:06 p.m., director of nursing (DON) stated R16's recliner was wet with urine and had a foul smell and she had to take it on 10/10/24 or 10/11/24. DON confirmed she did not ask permission to take the chair. DON further confirmed she was unsure who was going to clean the chair and if or when it would be returned. During interview on 10/15/24 at 10:20 a.m., social services director (SSD) stated she had not been involved in the conversation to remove R16's	21805			

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21805	Continued From page 31 recliner and was informed after it was removed. SSD further stated R16's recliner was very important to him when he admitted to the facility, and she would have expected R16's chair to be cleaned and immediately returned or a replacement chair offered and accepted prior to removing the chair. SSD further stated due to resident rights, they should have had his permission to remove the recliner. During interview on 10/15/24 at 1:10 p.m., administrator stated they had a discussion about the recliner and decided to remove it due to odor and infection control. Administrator stated she was unsure if anyone confirmed permission from R16. A policy on resident rights and personal property was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise applicable resident rights policies and procedures. DON or designee could re-educate staff on the policies and procedures to ensure knowledge. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine compliance and the need for further monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805			