Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 6, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: October 10, 2023

Dear Administrator:

On October 25, 2023, we notified you a remedy was imposed. On November 14, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 8, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 9, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 25, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 9, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 8, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division

An equal opportunity employer.

Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 6, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

Re: Reinspection Results
Event ID: ATTK12

Dear Administrator:

On November 14, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 10, 2023. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 25, 2023

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

RE: CCN: 245473
Cycle Start Date: October 10, 2023

Dear Administrator:

On October 10, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 9, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 9, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 9, 2023.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by November 9, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bayside Manor Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 9, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 10, 2024 if your facility does not achieve

substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: ATTK11

Dear Administrator:

The above facility was surveyed on October 5, 2023 through October 10, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	10/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 10/5/23, 10/6/23 and 10/10/23, a complaint 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 when they will be completed. The following complaints were reviewed. H54736146C (MN00097303) and H54736302C (MN00097510) with a licensing order issued at 0815 and 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours a day in a 24-hour for 22 days between 4/30/23 through 9/28/23. This had the potential to effect all residents residing in the facility. Findings include: Review of the third quarter payroll-based journal (PBJ) report indicated that the facility did not meet requirement of registered nurse (RN) coverage for 8 consecutive hours, for the following dates: 4/30/23 5/20/23 5/21/23 6/3/23 6/4/23 6/12/23	2 810	F727 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to	11/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	10/10/2023

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

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2 810	Continued From page 3 Review of the facility schedule and director of nursing (DON) and interim DON (IDON) times cards from 6/15/23 through 10/5/23, identified no RN coverage as follows: 6/16/23- RN only in building from 8:14 a.m. to 3:15 p.m. 6/18/23- RN in building only from 7:17 a.m. to 11:16 a.m. 6/25/23- no RN on schedule 7/1/23- no RN on schedule 7/2/23- no RN on schedule 8/6/23- no RN on schedule 8/29/23 through 9/2/23, no RN on the schedule. 9/5/23- no RN for 8 consecutive hours 9/8/23- no RN for 8 consecutive hours 9/24/23- no RN on schedule 9/28/23- no RN on schedule. During interview on 10/6/23 at 11:55 a.m., nurse manager (NM)-A stated an awareness there were days without RN coverage. NM-A could not offer any further information. During interview on 10/6/23 at 12:50 p.m., IDON explained Monday through Friday the she was the RN in building for the 8 consecutive hours. Previous DON's last day was 9/27/23. IDON indicated beginning on 9/27/23 herself and corporate nurse leader shared the responsibility of working to ensure there was an RN who worked 8 consecutive hours every day. During an interview on 10/6/23 at 1:55 p.m., administrator stated RN coverage is a struggle with agency staff either not showing up or calling in. During Monday through Friday the IDON was usually in the building to cover the eight consecutive hours, and the facility would usually try to have agency RN's on the schedule when	2 810	the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. -The process for satisfying this requirement has been reviewed and revised as needed to ensure RN coverage is reviewed daily. -All residents in the facility have the potential to be affected if this requirement is not met. -Director of Nursing will provide RN coverage 8 hours a day, 5 days a week. Outside agency RNs will continue to be utilized to attempt to fulfill the daily RN coverage requirement. An RN is always available by phone for questions. Facility will continue to actively recruit and hire RNs. Facility offers sign on bonuses offered for RNs, referral and retention bonuses for current staff. Corporate recruiter is actively looking for RNs. -A waiver has been submitted to MDH for the 8-hour RN requirement. -Director of Nursing, Administrator, and Scheduler have all been educated on this requirement. -Director of Nursing or designee is responsible party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	10/10/2023

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2 810	Continued From page 4 IDON was not present in facility. Review of facility's undated staffing policy did not indicate RN coverage hours. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided 8 hours per day, 7 days per week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810	-Corrective action will be completed on or before 11/8/23.	
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:	2 830		11/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE MANOR LLC	640 THIRD STREET GAYLORD, MN 55334

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2 830	Continued From page 5 Based on observation, interview, and document review the facility failed to ensure safe transfer techniques using a gait belt and failed to complete a comprehensive post fall analysis and investigation for 2 of 3 residents (R1, R2) reviewed for falls. The facility's failures resulted in actual harm when R1 sustained a pelvic and R2 sustained a rib fracture. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/23/23, identified R2 had diagnoses that included hemiplegia/hemiparesis with fluctuating cognition. R1 required extensive physical assistance from one staff for bed mobility, transfers, locomotion on and off the unit, dressing, and toilet use. R1 had impaired balance and was not steady with transitions without staff assistance to maintain balance. R1 had functional range of motion impairments on one side and used a walker and wheelchair. The MDS also indicated R1 did not have any falls since the last assessment. R1's fall care plan dated 9/30/22 identified R1 was at risk for falls related to alteration in mobility, altered balance, unsteady gait, pain, and buckling of knee joints. Corresponding interventions included: -Physical/occupational therapy to evaluate and treat for strengthening related to increased weakness noted with ambulation (start date 11/10/2022.) -Analyze previous resident falls to determine whether pattern/trend can be addressed (start date 3/10/22), -R1 to ear proper and non slip footwear (start date 10/10/22). -Encourage R1 to use handrails or assistive	2 830	F689 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F689 – Free of Accident Hazards/Supervision/Devices¿ A comprehensive post fall analysis (Incident Review and Analysis) were completed for both R1 and R2. During ambulation, R1's legs gave out and nursing assistant attempted to lower resident to the floor but lost her balance.	

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	00619	A. BUILDING: _____ B. WING _____	10/10/2023

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2 830	Continued From page 6 devices properly. Make sure before letting go of grab bar that she has her footing (start date 10/10/22) -Physical/occupational therapy to evaluate and treat related to weakness, felling of knees giving out (start date 1/11/23.) R1's fall care plan included an intervention dated 1/17/23, but canceled on 4/25/23, included "when resident is feeling week and/or feels that she is unsteady, staff is to use two assist for safety." R1's mobility care plan dated 4/7/23, indicated R1 had limited physical mobility related to hemiplegia and hemiparesis status post cerebral vascular accident (stroke) affecting the right dominant side. R1 required minimum assist of one staff with gait belt and walker for transfers. For ambulation R1 required moderate assist of one staff with gait belt and walker with wheelchair to follow. Care plan also indicated R1 could tolerate walking 50 feet. R1's incident progress note dated 6/30/23 at 8:46 a.m., indicated nurse was called R1's room. R1 was sitting on the floor in her room by the closet, nursing assistant (NA) was with the resident. Gait belt was on the R1. NA reported she had lowered R1 to the floor. R1 had a large lump with a bruise on her right side of her forehead that measured 4.5 centimeters (cm) x 4.5 cm. R1 was assisted off the floor with a full body mechanical lift and into her recliner chair. R1 did not complain of pain at the time. R1's Incident Review and Analysis dated 6/30/23, identified on 6/30/23 at 8:05 a.m. when R1 was walking with a gaitbelt on from the bathroom with a nursing assistant. No other information was included in the description of the fall. Contributing factors were identified were R1 had unsteady gait and no other potential causal factors were	2 830	Nursing assistant and R1 fell to the floor. At the time of the incident, walker and gait belt were in use and care plan was being followed. Upon return from the hospital, PT immediately evaluated for appropriate transfers and ambulation. During complaint survey, investigation into facility reported incident with R2 was still in progress and 5 day had not yet been submitted. Statements and interviews with R2 and nursing assistants reveal inconsistencies in the details of the incident.¿It was determined that all transfers were performed with the assistance of 2 staff and gait belt, per care plan. Nursing assistants all identified difficulty with transferring resident at times and indicated that on at least one occasion, R2 required staff to “hold her up by the gait belt” after having difficulty standing and being unable to complete transfer to the toilet. R2 has been routinely seen by PT/OT since 09/08/23 for muscle weakness, difficulty in walking, Parkinsons disease, and mild cognitive impairment to assess transfers and ambulation, and to improve strength, mobility, and safety. ¿ All residents have the potential to be affected.¿¿ Like residents have been reviewed for appropriate transfer status to ensure accuracy. All residents were reviewed for completion of a comprehensive post fall analysis within the last two weeks. Director of Nursing, LPN Care Coordinator were educated on the expectations of a timely completion of the Incident Review and	

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2 830	Continued From page 7 identified. The review did not identify an intervention to reduce and/or prevent re-current falls associated with unsteady gait. Further the review did not include a root cause analysis and did not identify interventions associated causal analysis that identified root cause R1's hospital After Visit Summary (AVS) dated 6/30/23, indicated R1 was seen in the emergency department for a fall and diagnosed with closed left pubic ramus fracture, hematoma (bruise) of right thigh, and contusion of forehead. The AVS did not include details of the visit. R1 was discharged back to the facility on 6/30/23. R1's progress note dated 6/30/23 at 5:24 p.m. indicated R1 returned to the facility from the hospital. R1's progress note dated 6/30/23 at 6:15 p.m. indicated when physical therapy and nursing transferred R1 to the toilet and was passing gas when R1 suddenly went unresponsive. Staff called 911. Sternal rub brought R1 "around", opened her eyes, and was conversing with staff when paramedics arrived. R1 was transferred back to the hospital for further evaluation. R1's hospital Admission record dated 7/1/23 at 12:15 a.m. indicated R1 presented to the ED for right facial scalp contusion, pelvic fracture, and large right thigh hematoma, and acute blood loss anemia. R1 had a fall where her right leg gave out on the morning of 6/30/23. She was discharged back to the facility however, when she was on the toilet suffered a syncopal event where she was seen to have loss consciousness for over 10 minutes. Noted to have ongoing anemia due to blood loss, but normal vital signs. Physical exam identified R1 had scalp hematoma over the	2 830	Analysis after a fall. Re education will be completed with nursing assistants on the appropriate use of gait belts and safe transfers. Director of Nursing or designee will conduct random audits for timely completion of the Incident Review and Analysis after a fall and appropriate transfers and gait belt use. Audits will be conducted weekly x 4, monthly x 2 and reported to QA committee for further review and recommendations.¿ Corrective action will be completed on or before 11/8/23. ¿	

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2 830	Continued From page 8 right frontal scalp with some bruising, no active bleeding. Able to move right hip actively, significant ecchymoses (bruising) on the right lateral hip and over right buttock. Right thigh hematoma likely large enough that it is causing acute blood loss anemia that was symptomatic with subsequent syncope that was multifactorial from micturition and blood loss. R1 was discharged back to the facility on 7/3/23, with diagnoses that included mildly comminuted fracture of the left superior and inferior pubic rami near the pubic symphysis, acute blood loss from hematoma, recurrent falls, and hematoma of right thigh and scalp. During an interview on 10/5/23 at 1:14 p.m., R1 indicated she remembered the fall on 6/30/23 and remembered the NA who was involved. R1 explained NA-L had walked her out of the bathroom with a gait belt on to her reclining chair. R1 was in front and facing her chair when NA-L let go of her gait belt to get something out of her closet. While NA-L was doing that her leg gave out and she fell to the floor. R1 stated with conviction she was not lowered to the floor. R1 could not recall anything after falling, however she remembered getting a bump on the right side of her face and being told she broke her pelvis. R1 was not aware of what she hit her head on. Once R1 fell, R1 could not remember anything after that. R1 stated she used to be able to walk into the bathroom with one staff, but now she she had to use the mechanical standing lift with two staff to go to the bathroom and was working with therapy. During an interview on 10/5/23 at 2:02 p.m., NA-L indicated stated she was working with R1 on 6/30/23. NA-L explained she was certified as an NA at the beginning of September and had never	2 830		

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2 830	Continued From page 9 worked with R1 before. NA-L at the time of the fall R1 was assist of one with a gait belt. When she transferred R1 to the bathroom with one and a gait belt it made her uncomfortable because R1 was unsteady and really weak. NA-L stated she used the radio to confirm with other staff R1 was one assist. She was told "yes". NA-L stated when she was walking R1 out of the bathroom with the gait belt on, R1's leg gave out and she lowered her to the floor and "went down" with her. NA-L had been behind R1 and to the side (could not recall which side) when R1 started falling. NA-L called for assistance over her radio for help. NA-L stated R1 hit the right side of her head because it was swollen but did not know what she hit her head on. NA-L stated that at the time of the fall, R1 was assist of one staff, with gait belt and walker for transfers and walking in room. During interview on 10/5/23 at 4:10 P.M., social worker (SW) indicated she thought NA-L had been shadowing someone else and was still in training at the time of the fall. There was another NA who had been working with NA-L that day however, that NA had responded to another call light, and NA-L responded to R1's call light by herself. SW was the first staff person to arrive to R1's room after NA-L called for help over the radio. Upon entering the room, R1's was on the floor facing the bathroom and both closet doors open behind her. NA-L was behind R1 holding R1 in a sitting position. R1's right leg was bent at the knee and underneath her with a goose egg on the right forehead. SW stated R1 had reported she had been standing by her chair and the next thing she knew she was on the floor. Later that morning R1 had kept saying that she was having shooting pain in her right arm, which she hadn't any feeling in that arm for 40 years due to stroke. R1 was sent to the emergency room. SW did not	2 830		

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2 830	Continued From page 10 think the care plan was followed at the time and questioned if NA-L thoroughly understood how to care for R1. SW indicated she was not interviewed by previous administration as part of the fall investigation despite being the first person to respond. During an interview on 10/10/23 at 1:11 p.m., licensed practical nurse (LPN)-D stated she was called to R1's room and found R1 sitting on the floor between the closet and the recliner, R1 was closer to the closet. The closet door was open and the bathroom door was slightly opened. NA-L was standing behind her. R1's right leg was bent underneath her and the left leg was straight in front of her. R1 had a gait belt on. LPN-D was told by NA-L, she was walking R1 back from the bathroom to the chair. NA-L wanted to change the pad on the chair and turned to get the pad out of the closet and then R1 fell. LPN-D remembered R1 had bruise or a bump on her forehead. LPN-D indicated later that morning R1 had started to complain of pain and was sent to the emergency room for further evaluation. LPN-D thought NA-L "had the proper training, but probably not competent enough" to work with R1 independently. During an interview on 10/6/23 at 3:16 p.m., physical therapist (PT)-A stated R1 had right sided weakness. With right sided weakness, NA's should be on the resident's right hand side and maybe a half a step back. Their hands should be on the back part of the belt. PT-A indicated the position in which R1 was found in after the fall was not consistent with a controlled lowering to the floor after her leg gave out, however was not there at the time. PT-A indicated therapy used to do safe transfer training that would teach NA-A how to transfer and use the gait belt however,	2 830		

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2 830	Continued From page 11 they had stopped some time ago. During an interview on 10/10/23 at 10:17 a.m. interim director of nursing (IDON) indicated R1's fall investigation could not be found. She reached out to the previous IDON who reported she had completed the investigation and should be at the facility. Since they could not find the investigation, the facility completed the investigation on 10/6/23, all the staff who were working at the time of the fall were interviewed. IDON explained according to interviews it was a "controlled fall" until NA-L fell too. NA-L had reported that before the fall R1 had been leaning to the right and indicated she did not request assistance from other staff. R1 had reported NA-L was not holding onto the gait belt when her leg gave out. IDON indicated NA-L had completed the NA training and was competent at the time of the fall. During an interview on 10/10/23 at 11:08 A.M., administrator stated they were not able to find the investigation for R1's fall on 6/30/23. R2 During an observation and interview on 10/6/23 at 9:15 a.m. R2 was seated in her wheelchair with a gait belt applied loosely around her stomach. R2 explained she needed assist of two staff to pivot transfer. On 10/4/23 after breakfast during a transfer one NA was standing in front of her, grabbed the gait belt and twisted it, digging her knuckles in to R2's left rib cage. R2 stated she had instant pain, she said "Ouch!!" right away. The NA laughed when R2 reported she thought her rib was broken. R2 thought it was NA-R who dug her knuckles in but could not be for sure. R2 did not remember who the other NA was that was assisting with the transfer. R2 stated she was	2 830		

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2 830	Continued From page 12 given Tylenol for the pain, which helped a little bit. R2 stated she still had chest pain when she stands up and walks, but did not hurt when she laid down or when she was breathing. R2's quarterly MDS dated 7/20/23, indicated intact cognition with diagnoses of Parkinson's disease, osteoporosis, anxiety, dizziness, anxiety disorder and was legally blind. R2 required extensive assist of one staff for bed mobility, transfers, walking in room, locomotion on and off unit, and toilet use. R2's fall care plan dated 4/18/23, directed the following: -Encourage R2 to stand tall, stop and take rests when needed and assist R2 to sit in wheelchair when needed (start date 4/20/23) R2's activity of daily living care plan dated 4/7/23, directed the following: -Transfers: minimal assist of two with gait belt and walker. Cue to stand tall if unable to stand please use Hoyer (start date 9/26/23). R2's progress note dated 10/5/23 at 2:00 p.m., indicated that at 8:50 a.m., nurse manager (NM)-A was in room to assist nursing assistant (NA)-L with a pivot transfers of R2 from bed to wheelchair to the bathroom. R2 stated that NA-R hit R2 in the left rib cage area the day before and R2 was having pain. R2 was still able to lift left arm above her head and to grab hold of grab bar and stand up. Skin assessment completed at this time, no new concerns noted, continued to have redness under left breast that was identified on 10/4/23. Provider was notified at 12:20 p.m., order received for x-ray, and R2 went to local clinic at 1:31 p.m. Review of R2's x-ray report dated 10/5/23, at 1:15	2 830		

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2 830	Continued From page 13 p.m. indicated a possible left seventh rib fracture. A facility reported incident report (FRI) submitted to the State Agency on 10/5/23, at 12:11 p.m. alleged on 10/4/23 at 8:00 a.m. R2 reported to the social worker (SW) NAs were transferring her into bed. R2 stated an NA dug her knuckles into the side of her ribs/breast area causing pain when she was being transferred into bed. During an interview on 10/6/23 at 10:40 a.m., NA-R stated R2 required assist of two staff for pivot transfer and she was able to make her needs known. NA-R stated on 10/4/23, she thought R2 was weak and thought she could have used the standing lift or full body lift, but R2 would refuse and it would take too long. NA-R explained on 10/4/23, when she went to assist NA-L with R2's transfer from the bed the belt was on really loose. When they stood R2 up NA-L tightened the gait belt by twisting it versus using the buckle portion. After R2 sat down NA-R, she tightened the gait belt appropriately, switched sides with NA-L, and transferred R2 from wheelchair to the toilet. NA-R explained NA-L had not applied the gait belt correctly or tightened it up correctly. NA-R reiterated R2 was not transferring well that morning. NA-R did not remember R2 reporting pain during the transfer. During an interview on 10/6/23, at 3:16 p.m. physical therapist (PT)-A reviewed R2's incident and indicated staff did not apply the gaitbelt correctly. Staff should never twist the gaitbelt for tightening. the gaitbelt should be straight and not turned; the buckle should be used. The gait belt should be cinched tighter once the resident stands up. PT-A explained there used to be transfer training which included gait belt training, however the facility was no longer providing.	2 830		

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2 830	Continued From page 14 During an interview on 10/10/23 at 12:25 p.m., NA-C indicated she was familiar with R2's transfers. NA-C explained R2 hunches over and thought it was hard for her to stand. Sometimes R2's legs were very weak, so then we have to lift or provide more support. NA-C reported on 10/4/23, she had transferred R2 twice with NA-L. One of the times R2 reported pain in her left chest. NA-C stated the gait belt was snug and placed correctly. The physician had been in the facility that day and checked R2 for injuries shortly after that transfer. During an interview on 10/6/23 at 12:50 p.m. interim director of nursing (IDON) stated they have suspended NA-L and NA-R until their investigation was completed. NA-C they have ruled out for abuse, through their investigation. IDON stated they thought that R2 had mistaken NA-L for NA-R per their investigation at this time. NA-L was assigned to R2 on 10/4/23. Review of facility abuse policy stated residents are not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff of other agencies serving the individual, family members or legal guardians, friend or other individuals, or self-abuse. 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 interventioins are being implemented. They 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	2 830		

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2 830	Continued From page 15 results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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F 000	INITIAL COMMENTS On 10/5/23, 10/6/23, and 10/10/23 a standard abbreviated survey was conducted at your facility. 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: H54736146C (MN00097303) and H54736302C (MN00097510) and deficiency cited at F609 and F689. Deficient practice was identified related to incidental finding F727. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		11/8/23

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

Electronically Signed | 11/02/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	C 10/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report a fall with major injury to the state agency (SA), within the two-hour requirement, for 1 of 3 residents (R1) reviewed, when R1 had a fall with a fractured pelvis. Findings include: R1's annual minimum data set (MDS) dated 8/23/23, indicated a fluctuating cognition with diagnoses of arthritis, other fracture, and hemiplegia/hemiparesis. R1 required extensive assist of two staff for bed mobility, transfers, locomotion on and off the unit, dressing, and toilet use. R1 did not walk and had range of motion (ROM) limitations on one side of her body. R1 used a wheelchair. R1 had no falls noted on	F 609	F609 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	

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F 609	Continued From page 2 MDS. R1's incident progress note dated 6/30/23 at 8:46 a.m., indicated nurse was called R1's room. R1 was sitting on the floor in her room by the closet, nursing assistant (NA) was with the resident. Gait belt was on the R1. NA reported she had lowered R1 to the floor. R1 had a large lump with a bruise on her right side of her forehead that measured 4.5 centimeters (cm) x 4.5 cm. R1 was assisted off the floor with a full body mechanical lift and into her recliner chair. R1 did not complain of pain at the time. R1's hospital After Visit Summary (AVS) dated 6/30/23, indicated R1 was seen in the emergency department for a fall and diagnosed with closed left pubic ramus fracture, hematoma (bruise) of right thigh, and contusion of forehead. The AVS did not include details of the visit. R1 was discharged back to the facility on 6/30/23 Review of facility reported incidents identified R1's fall was not reported to the SA. During an interview on 10/6/23 at 11:55 a.m. nurse manager (NM)-A reviewed R1's fall incident report and stated the incident should have been reported to the SA within two hours. NM-A explained after an incident occurred nurse managers could report to the SA if required. During an interview on 10/6/23 at 12:50 p.m., interim director of nursing (IDON) indicated if staff were unsure if something should be reported to SA, staff were encouraged to reach out to herself, NM-A, social worker (SW), or administrator. The social worker and administrator were usually the person's responsible for submitting a report to the	F 609	Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F609 – Reporting of Alleged Violations¿ Director of Nursing and Administrator reviewed the facility "Abuse Prohibition/Vulnerable Adult Policy" and stated understanding of reporting requirements for falls with major injury. A thorough investigation was completed and determined that concerns for abuse and neglect were unsubstantiated.¿¿ All residents have the potential to be affected.¿ Monarch corporate policy titled "Abuse Prohibition/Vulnerable Adult Policy" was reviewed and revised 09/18/23 to include "All serious injuries, even those considered accidental… examples of serious injury include but are not limited to falls with major injury (including fractures, closed head injury, internal bleeding and death)… must be reported to OHFC online reporting process not later than 2 hours if the incident resulted in serious bodily injury." Staff were reeducated on	

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F 609	Continued From page 3 SA. IDON also stated facility policy recently changed to report any fractures to SA. IDON stated R1's incident should have been reported to SA once the facility found out of the fractured pelvis. During interview on 10/6/23 at 1:55 P.M., administrator indicated according to previous policy that was in effect on date of fall, 6/30/23, if reason of the fracture was known the company policy did not include to report to SA but the company has since reworded the policy in 9/2023 to include reporting all fractures to SA. Administrator stated that they could not find the investigation for R1's incident on 6/30/23. Administrator stated the incident should have been reported to SA within two hours facility finding out of the fracture. Review of facility policy titled Fall Prevention and Management, dated 9/2023, under reporting to SA #2 indicated Avoidable falls with serious injury shall be reported to the SA through the online reporting process immediately but no later than two hours after identifying the injury.	F 609	facility Abuse Prevention/Vulnerable Adult Policy, including immediately reporting allegations of abuse.¿ Administrator or designee will conduct random audits of staff understanding of facility Abuse Prevention/Vulnerable Adult Policy and when to report allegations of abuse. Audits will be conducted weekly x 4, monthly x 2 and reported to QA committee for further review and recommendations. Corrective action will be completed on or before 11/8/23.	
F 689 SS=G	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:	F 689		11/8/23

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F 689	Continued From page 4 Based on observation, interview, and document review the facility failed to ensure safe transfer techniques using a gait belt and failed to complete a comprehensive post fall analysis and investigation for 2 of 3 residents (R1, R2) reviewed for falls. The facility's failures resulted in actual harm when R1 sustained a pelvic and R2 sustained a rib fracture. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/23/23, identified R2 had diagnoses that included hemiplegia/hemiparesis with fluctuating cognition. R1 required extensive physical assistance from one staff for bed mobility, transfers, locomotion on and off the unit, dressing, and toilet use. R1 had impaired balance and was not steady with transitions without staff assistance to maintain balance. R1 had functional range of motion impairments on one side and used a walker and wheelchair. The MDS also indicated R1 did not have any falls since the last assessment. R1's fall care plan dated 9/30/22 identified R1 was at risk for falls related to alteration in mobility, altered balance, unsteady gait, pain, and buckling of knee joints. Corresponding interventions included: -Physical/occupational therapy to evaluate and treat for strengthening related to increased weakness noted with ambulation (start date 11/10/2022.) -Analyze previous resident falls to determine whether pattern/trend can be addressed (start date 3/10/22), -R1 to ear proper and non slip footwear (start date 10/10/22).	F 689	F689 s/s D: Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F689 – Free of Accident Hazards/Supervision/Devices¿ A comprehensive post fall analysis (Incident Review and Analysis) were completed for both R1 and R2. During ambulation, R1's legs gave out and nursing assistant attempted to lower	

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F 689	Continued From page 5 -Encourage R1 to use handrails or assistive devices properly. Make sure before letting go of grab bar that she has her footing (start date 10/10/22) -Physical/occupational therapy to evaluate and treat related to weakness, felling of knees giving out (start date 1/11/23.) R1's fall care plan included an intervention dated 1/17/23, but canceled on 4/25/23, included "when resident is feeling week and/or feels that she is unsteady, staff is to use two assist for safety." R1's mobility care plan dated 4/7/23, indicated R1 had limited physical mobility related to hemiplegia and hemiparesis status post cerebral vascular accident (stroke) affecting the right dominant side. R1 required minimum assist of one staff with gait belt and walker for transfers. For ambulation R1 required moderate assist of one staff with gait belt and walker with wheelchair to follow. Care plan also indicated R1 could tolerate walking 50 feet. R1's incident progress note dated 6/30/23 at 8:46 a.m., indicated nurse was called R1's room. R1 was sitting on the floor in her room by the closet, nursing assistant (NA) was with the resident. Gait belt was on the R1. NA reported she had lowered R1 to the floor. R1 had a large lump with a bruise on her right side of her forehead that measured 4.5 centimeters (cm) x 4.5 cm. R1 was assisted off the floor with a full body mechanical lift and into her recliner chair. R1 did not complain of pain at the time. R1's Incident Review and Analysis dated 6/30/23, identified on 6/30/23 at 8:05 a.m. when R1 was walking with a gaitbelt on from the bathroom with a nursing assistant. No other information was included in the description of the fall. Contributing	F 689	resident to the floor but lost her balance. Nursing assistant and R1 fell to the floor. At the time of the incident, walker and gait belt were in use and care plan was being followed. Upon return from the hospital, PT immediately evaluated for appropriate transfers and ambulation. During complaint survey, investigation into facility reported incident with R2 was still in progress and 5 day had not yet been submitted. Statements and interviews with R2 and nursing assistants reveal inconsistencies in the details of the incident.¿It was determined that all transfers were performed with the assistance of 2 staff and gait belt, per care plan. Nursing assistants all identified difficulty with transferring resident at times and indicated that on at least one occasion, R2 required staff to “hold her up by the gait belt” after having difficulty standing and being unable to complete transfer to the toilet. R2 has been routinely seen by PT/OT since 09/08/23 for muscle weakness, difficulty in walking, Parkinsons disease, and mild cognitive impairment to assess transfers and ambulation, and to improve strength, mobility, and safety. ¿ All residents have the potential to be affected.¿¿ Like residents have been reviewed for appropriate transfer status to ensure accuracy. All residents were reviewed for completion of a comprehensive post fall analysis within the last two weeks.	

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F 689	Continued From page 6 factors were identified were R1 had unsteady gait and no other potential causal factors were identified. The review did not identify an intervention to reduce and/or prevent re-current falls associated with unsteady gait. Further the review did not include a root cause analysis and did not identify interventions associated causal analysis that identified root cause R1's hospital After Visit Summary (AVS) dated 6/30/23, indicated R1 was seen in the emergency department for a fall and diagnosed with closed left pubic ramus fracture, hematoma (bruise) of right thigh, and contusion of forehead. The AVS did not include details of the visit. R1 was discharged back to the facility on 6/30/23. R1's progress note dated 6/30/23 at 5:24 p.m. indicated R1 returned to the facility from the hospital. R1's progress note dated 6/30/23 at 6:15 p.m. indicated when physical therapy and nursing transferred R1 to the toilet and was passing gas when R1 suddenly went unresponsive. Staff called 911. Sternal rub brought R1 "around", opened her eyes, and was conversing with staff when paramedics arrived. R1 was transferred back to the hospital for further evaluation. R1's hospital Admission record dated 7/1/23 at 12:15 a.m. indicated R1 presented to the ED for right facial scalp contusion, pelvic fracture, and large right thigh hematoma, and acute blood loss anemia. R1 had a fall where her right leg gave out on the morning of 6/30/23. She was discharged back to the facility however, when she was on the toilet suffered a syncopal event where she was seen to have loss consciousness for	F 689	Director of Nursing, LPN Care Coordinator were educated on the expectations of a timely completion of the Incident Review and Analysis after a fall. Re education will be completed with nursing assistants on the appropriate use of gait belts and safe transfers. Director of Nursing or designee will conduct random audits for timely completion of the Incident Review and Analysis after a fall and appropriate transfers and gait belt use. Audits will be conducted weekly x 4, monthly x 2 and reported to QA committee for further review and recommendations.¿ Corrective action will be completed on or before 11/8/23. ¿	

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F 689	Continued From page 7 over 10 minutes. Noted to have ongoing anemia due to blood loss, but normal vital signs. Physical exam identified R1 had scalp hematoma over the right frontal scalp with some bruising, no active bleeding. Able to move right hip actively, significant ecchymoses (bruising) on the right lateral hip and over right buttock. Right thigh hematoma likely large enough that it is causing acute blood loss anemia that was symptomatic with subsequent syncope that was multifactorial from micturition and blood loss. R1 was discharged back to the facility on 7/3/23, with diagnoses that included mildly comminuted fracture of the left superior and inferior pubic rami near the pubic symphysis, acute blood loss from hematoma, recurrent falls, and hematoma of right thigh and scalp. During an interview on 10/5/23 at 1:14 p.m., R1 indicated she remembered the fall on 6/30/23 and remembered the NA who was involved. R1 explained NA-L had walked her out of the bathroom with a gait belt on to her reclining chair. R1 was in front and facing her chair when NA-L let go of her gait belt to get something out of her closet. While NA-L was doing that her leg gave out and she fell to the floor. R1 stated with conviction she was not lowered to the floor. R1 could not recall anything after falling, however she remembered getting a bump on the right side of her face and being told she broke her pelvis. R1 was not aware of what she hit her head on. Once R1 fell, R1 could not remember anything after that. R1 stated she used to be able to walk into the bathroom with one staff, but now she she had to use the mechanical standing lift with two staff to go to the bathroom and was working with therapy.	F 689		

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F 689	Continued From page 8 During an interview on 10/5/23 at 2:02 p.m., NA-L indicated stated she was working with R1 on 6/30/23. NA-L explained she was certified as an NA at the beginning of September and had never worked with R1 before. NA-L at the time of the fall R1 was assist of one with a gait belt. When she transferred R1 to the bathroom with one and a gait belt it made her uncomfortable because R1 was unsteady and really weak. NA-L stated she used the radio to confirm with other staff R1 was one assist. She was told "yes". NA-L stated when she was walking R1 out of the bathroom with the gait belt on, R1's leg gave out and she lowered her to the floor and "went down" with her. NA-L had been behind R1 and to the side (could not recall which side) when R1 started falling. NA-L called for assistance over her radio for help. NA-L stated R1 hit the right side of her head because it was swollen but did not know what she hit her head on. NA-L stated that at the time of the fall, R1 was assist of one staff, with gait belt and walker for transfers and walking in room. During interview on 10/5/23 at 4:10 P.M., social worker (SW) indicated she thought NA-L had been shadowing someone else and was still in training at the time of the fall. There was another NA who had been working with NA-L that day however, that NA had responded to another call light, and NA-L responded to R1's call light by herself. SW was the first staff person to arrive to R1's room after NA-L called for help over the radio. Upon entering the room, R1's was on the floor facing the bathroom and both closet doors open behind her. NA-L was behind R1 holding R1 in a sitting position. R1's right leg was bent at the knee and underneath her with a goose egg on the right forehead. SW stated R1 had reported she had been standing by her chair and the next thing	F 689		

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F 689	Continued From page 9 she knew she was on the floor. Later that morning R1 had kept saying that she was having shooting pain in her right arm, which she hadn't any feeling in that arm for 40 years due to stroke. R1 was sent to the emergency room. SW did not think the care plan was followed at the time and questioned if NA-L thoroughly understood how to care for R1. SW indicated she was not interviewed by previous administration as part of the fall investigation despite being the first person to respond. During an interview on 10/10/23 at 1:11 p.m., licensed practical nurse (LPN)-D stated she was called to R1's room and found R1 sitting on the floor between the closet and the recliner, R1 was closer to the closet. The closet door was open and the bathroom door was slightly opened. NA-L was standing behind her. R1's right leg was bent underneath her and the left leg was straight in front of her. R1 had a gait belt on. LPN-D was told by NA-L, she was walking R1 back from the bathroom to the chair. NA-L wanted to change the pad on the chair and turned to get the pad out of the closet and then R1 fell. LPN-D remembered R1 had bruise or a bump on her forehead. LPN-D indicated later that morning R1 had started to complain of pain and was sent to the emergency room for further evaluation. LPN-D thought NA-L "had the proper training, but probably not competent enough" to work with R1 independently. During an interview on 10/6/23 at 3:16 p.m., physical therapist (PT)-A stated R1 had right sided weakness. With right sided weakness, NA's should be on the resident's right hand side and maybe a half a step back. Their hands should be on the back part of the belt. PT-A indicated the	F 689		

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F 689	Continued From page 10 position in which R1 was found in after the fall was not consistent with a controlled lowering to the floor after her leg gave out, however was not there at the time. PT-A indicated therapy used to do safe transfer training that would teach NA-A how to transfer and use the gait belt however, they had stopped some time ago. During an interview on 10/10/23 at 10:17 a.m. interim director of nursing (IDON) indicated R1's fall investigation could not be found. She reached out to the previous IDON who reported she had completed the investigation and should be at the facility. Since they could not find the investigation, the facility completed the investigation on 10/6/23, all the staff who were working at the time of the fall were interviewed. IDON explained according to interviews it was a "controlled fall" until NA-L fell too. NA-L had reported that before the fall R1 had been leaning to the right and indicated she did not request assistance from other staff. R1 had reported NA-L was not holding onto the gait belt when her leg gave out. IDON indicated NA-L had completed the NA training and was competent at the time of the fall. During an interview on 10/10/23 at 11:08 A.M., administrator stated they were not able to find the investigation for R1's fall on 6/30/23. R2 During an observation and interview on 10/6/23 at 9:15 a.m. R2 was seated in her wheelchair with a gait belt applied loosely around her stomach. R2 explained she needed assist of two staff to pivot transfer. On 10/4/23 after breakfast during a transfer one NA was standing in front of her, grabbed the gait belt and twisted it, digging her	F 689		

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F 689	Continued From page 11	F 689		

knuckles in to R2's left rib cage. R2 stated she had instant pain, she said "Ouch!!" right away. The NA laughed when R2 reported she thought her rib was broken. R2 thought it was NA-R who dug her knuckles in but could not be for sure. R2 did not remember who the other NA was that was assisting with the transfer. R2 stated she was given Tylenol for the pain, which helped a little bit. R2 stated she still had chest pain when she stands up and walks, but did not hurt when she laid down or when she was breathing.

R2's quarterly MDS dated 7/20/23, indicated intact cognition with diagnoses of Parkinson's disease, osteoporosis, anxiety, dizziness, anxiety disorder and was legally blind. R2 required extensive assist of one staff for bed mobility, transfers, walking in room, locomotion on and off unit, and toilet use.

R2's fall care plan dated 4/18/23, directed the following:
-Encourage R2 to stand tall, stop and take rests when needed and assist R2 to sit in wheelchair when needed (start date 4/20/23)
R2's activity of daily living care plan dated 4/7/23, directed the following:
-Transfers: minimal assist of two with gait belt and walker. Cue to stand tall if unable to stand please use Hoyer (start date 9/26/23).

R2's progress note dated 10/5/23 at 2:00 p.m., indicated that at 8:50 a.m., nurse manager (NM)-A was in room to assist nursing assistant (NA)-L with a pivot transfers of R2 from bed to wheelchair to the bathroom. R2 stated that NA-R hit R2 in the left rib cage area the day before and R2 was having pain. R2 was still able to lift left arm above her head and to grab hold of grab bar

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	245473	A. BUILDING _____ B. WING _____	C 10/10/2023

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F 689	Continued From page 12 and stand up. Skin assessment completed at this time, no new concerns noted, continued to have redness under left breast that was identified on 10/4/23. Provider was notified at 12:20 p.m., order received for x-ray, and R2 went to local clinic at 1:31 p.m. Review of R2's x-ray report dated 10/5/23, at 1:15 p.m. indicated a possible left seventh rib fracture. A facility reported incident report (FRI) submitted to the State Agency on 10/5/23, at 12:11 p.m. alleged on 10/4/23 at 8:00 a.m. R2 reported to the social worker (SW) NAs were transferring her into bed. R2 stated an NA dug her knuckles into the side of her ribs/breast area causing pain when she was being transferred into bed. During an interview on 10/6/23 at 10:40 a.m., NA-R stated R2 required assist of two staff for pivot transfer and she was able to make her needs known. NA-R stated on 10/4/23, she thought R2 was weak and thought she could have used the standing lift or full body lift, but R2 would refuse and it would take too long. NA-R explained on 10/4/23, when she went to assist NA-L with R2's transfer from the bed the belt was on really loose. When they stood R2 up NA-L tightened the gait belt by twisting it versus using the buckle portion. After R2 sat down NA-R, she tightened the gait belt appropriately, switched sides with NA-L, and transferred R2 from wheelchair to the toilet. NA-R explained NA-L had not applied the gait belt correctly or tightened it up correctly. NA-R reiterated R2 was not transferring well that morning. NA-R did not remember R2 reporting pain during the transfer. During an interview on 10/6/23, at 3:16 p.m.	F 689		

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F 689	Continued From page 13 physical therapist (PT)-A reviewed R2's incident and indicated staff did not apply the gaitbelt correctly. Staff should never twist the gaitbelt for tightening. the gaitbelt should be straight and not turned; the buckle should be used. The gait belt should be cinched tighter once the resident stands up. PT-A explained there used to be transfer training which included gait belt training, however the facility was no longer providing. During an interview on 10/10/23 at 12:25 p.m., NA-C indicated she was familiar with R2's transfers. NA-C explained R2 hunches over and thought it was hard for her to stand. Sometimes R2's legs were very weak, so then we have to lift or provide more support. NA-C reported on 10/4/23, she had transferred R2 twice with NA-L. One of the times R2 reported pain in her left chest. NA-C stated the gait belt was snug and placed correctly. The physician had been in the facility that day and checked R2 for injuries shortly after that transfer. During an interview on 10/6/23 at 12:50 p.m. interim director of nursing (IDON) stated they have suspended NA-L and NA-R until their investigation was completed. NA-C they have ruled out for abuse, through their investigation. IDON stated they thought that R2 had mistaken NA-L for NA-R per their investigation at this time. NA-L was assigned to R2 on 10/4/23. Review of facility abuse policy stated residents are not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff of other agencies serving the individual, family members or legal guardians, friend or other individuals, or self-abuse.	F 689		

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F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours a day in a 24-hour for 22 days between 4/30/23 through 9/28/23. This had the potential to effect all residents residing in the facility. Findings include: Review of the third quarter payroll-based journal (PBJ) report indicated that the facility did not meet requirement of registered nurse (RN) coverage for 8 consecutive hours, for the following dates: 4/30/23 5/20/23 5/21/23 6/3/23 6/4/23 6/12/23	F 727	-The process for satisfying this requirement has been reviewed and revised as needed to ensure RN coverage is reviewed daily. -All residents in the facility have the potential to be affected if this requirement is not met. -Director of Nursing will provide RN coverage 8 hours a day, 5 days a week. Outside agency RNs will continue to be utilized to attempt to fulfill the daily RN coverage requirement. An RN is always available by phone for questions. Facility will continue to actively recruit and hire RNs. Facility offers sign on bonuses offered for RNs, referral and retention bonuses for current staff. Corporate recruiter is actively looking for RNs.	11/8/23

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F 727	Continued From page 15 Review of the facility schedule and director of nursing (DON) and interim DON (IDON) times cards from 6/15/23 through 10/5/23, identified no RN coverage as follows: 6/16/23- RN only in building from 8:14 a.m. to 3:15 p.m. 6/18/23- RN in building only from 7:17 a.m. to 11:16 a.m. 6/25/23- no RN on schedule 7/1/23- no RN on schedule 7/2/23- no RN on schedule 8/6/23- no RN on schedule 8/29/23 through 9/2/23, no RN on the schedule. 9/5/23- no RN for 8 consecutive hours 9/8/23- no RN for 8 consecutive hours 9/24/23- no RN on schedule 9/28/23- no RN on schedule. During interview on 10/6/23 at 11:55 a.m., nurse manager (NM)-A stated an awareness there were days without RN coverage. NM-A could not offer any further information. During interview on 10/6/23 at 12:50 p.m., IDON explained Monday through Friday the she was the RN in building for the 8 consecutive hours. Previous DON's last day was 9/27/23. IDON indicated beginning on 9/27/23 herself and corporate nurse leader shared the responsibility of working to ensure there was an RN who worked 8 consecutive hours every day. During an interview on 10/6/23 at 1:55 p.m., administrator stated RN coverage is a struggle with agency staff either not showing up or calling in. During Monday through Friday the IDON was usually in the building to cover the eight consecutive hours, and the facility would usually try to have agency RN's on the schedule when	F 727	-A waiver has been submitted to MDH for the 8-hour RN requirement. -Waiver letter is as follows: I am writing this letter to request a waiver regarding federal regulation F727 for Bayside Manor in Gaylord, MN. We currently have several registered nurse (RN) positions open and are actively recruiting for them. Unfortunately, being in a small, rural facility, RNs tend to be difficult to recruit. We are close to a clinic and hospital that also actively recruits RNs, making recruitment even more difficult. Our facility currently lacks RNs as a whole. We currently have two RN nurse leader positions open, including the Director of Nursing and MDS Coordinator/Nurse Manager. We are also seeking RNs for our floor nurse positions. We have found it to be difficult to fulfill our 8 hours of RN coverage, 7 days a week, most notably on the weekends. Over the last year we have received 3 RN applications, all of which were eligible for review. We offered all 3 applicants employment at our facility, and all 3 declined employment. We currently have several efforts in place to recruit RNs such as sign-on bonuses, retention bonuses for current staff, staff referral bonuses, and tuition reimbursement for our LPNs looking to further their nursing credentials. A job fair was attended in October 2023 in Hutchinson, MN and no applicants were received from this. RN job postings can be found online on Facebook, Indeed, LinkedIn, Handshake,	

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F 727	Continued From page 16 IDON was not present in facility. Review of facility's undated staffing policy did not indicate RN coverage hours.	F 727	MN Works, Care Providers, and the Monarch Healthcare Management website. Please see the current RN job posting attached to this letter. Weekly retention and recruitment meetings have been started with the Administrator, Human Resource Director, and Regional Corporate Recruiter. Bayside Manor utilizes several supplemental nursing agencies including: EShift, Shift Key, Clipboard, Grapetree, Divine, Evident, Healthcare Associates, Favor Staffing, and Minnesota Nurse Rescue. In addition, Monarch employes RNs through their own float pool. RN coverage is utilized through these agencies and pools when available, although due to the facility's location it can be difficult to find RNs through these methods as well. Knowing that it will become even more difficult for us to fulfill our 8 hours per day of RN coverage, we do, and will continue to, consider the acuity of our current residents as well as those who we review for admission if our request was approved. The health and safety of our residents is our top priority. The facilities Medical Director is aware of the RN staffing challenge, as well as the rounding physician. Residents and/or resident families will be notified of the RN waiver once approved. With the support of our interim Director of Nursing, corporate Regional Nurse Consultant, and outside agency floor RNs,	

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F 727	Continued From page 17	F 727	we will continue to put forth every effort to have an RN in the building for at least 8 hours a day, 7 days a week, and ensure we always have an RN on call. We are requesting this waiver to be granted until we can employ 4 full-time RNs (Director of Nursing, MDS Coordinator/Nurse Manager, and two floor RNs to cover each weekend) in an attempt to preserve the currently employed staff here at our facility. -Director of Nursing, Administrator, and Scheduler have all been educated on this requirement. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 11/8/23.	