Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 30, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: January 31, 2023

Dear Administrator:

On March 22, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 30, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

Re: Reinspection Results
Event ID: JVSP12

Dear Administrator:

On March 22, 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 January 31, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: January 31, 2023

Dear Administrator:

On January 31, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

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, 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 May 1, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 31, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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 01/31/2023

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 000	INITIAL COMMENTS On January 27, 2023, and January 31,2023, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54737637C (MN00090158), H54737978C (MN00090433), and H54738075C (MN00090678), with a deficiencies cited at F725 and F755. 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 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 725		3/16/23

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

Electronically Signed | 02/22/2023

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.

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F 725	Continued From page 1 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient nursing staff to provide care and services to 4 of 4 residents (R1, R2, R3, R4) in a timely manner who were dependent on staff for activities of daily living and voiced concerns with long call light response times. Findings include: R1's admission Minimum Data Set (MDS) dated 1/12/23, indicated an intact cognition and a need for extensive assist of two staff with bed mobility, transfers, dressing, toileting, and extensive assist of one staff for locomotion, and personal hygiene and total dependent on one person for bathing.	F 725	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 Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and	

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F 725	Continued From page 2 During an observation on 1/27/23 at 8:50 a.m. R1 remained in bed in her night clothes with her wraps to her lower legs and brace on left knee. During an observation on 1/27/23 at 9:20 a.m. R1's call light was on, NA-A answered it. Therapy was assisting resident to get up and dressed for the day. NA-A assisted PT with moderate assist to walk R1 to the bathroom and then left the room. During an interview on 1/27/23, at 2:50 p.m. R1 stated that she had to wait up to an hour or more for the staff to answer her call light. R1 stated that she has put on her call light when she feels like she has to go to the bathroom, but no one comes to answer her call light and then she is incontinent of urine and stool. R1 is prone to urinary tract infections. R1 stated that she does not feel safe in the facility. R2's quarterly MDS dated 12/28/22, indicated R2 had moderate cognitive impairment. R2 required extensive assist with two staff for bed mobility, transfers, and toilet use. Extensive assist of one for personal hygiene, locomotion, dressing and bathing. During a continuous observation on 1/27/23 that started at 9:32 a.m. and ended at 9:55 a.m. identified R2's call light had been on for 23 minutes before registered nurse (RN)-A entered R2's room. Review of the Call light log dated 1/27/23 identified R2's call light was activated for 29 minutes and five seconds. During an interview on 1/27/23 at 2:35 p.m. R2 stated it took staff a long time to answer her call light. Waiting for staff for long periods of time	F 725	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. F725 s/s E: -The process for satisfying this requirement has been reviewed and revised as needed to ensure residents who are dependent on staff for activities of daily living (ADLs) are provided care and services in a timely manner. -All residents in the facility dependent on staff for ADL's have the potential to be affected if this requirement is not met. -The electronic medical record, to include the plan of care, for R1, R2, R3, and R4 was reviewed and revised as needed to ensure there was no harm or lasting effects. -The facility completed an Ad Hoc QAPI for call lights and educated all staff on the facility's expectations for answering call lights to ensure residents who are dependent on staff for ALDs are provided care and services in a timely manner. -The schedule is reviewed daily by DON or designee, Scheduler, and/or Administrator or designee, to ensure staffing levels continue to be appropriate pursuant to Minnesota Administrative Rules 4658.0510 - Nursing Personnel. Staffing is tracked and audited daily	

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F 725	Continued From page 3 upset her and made her feel unsafe. R3's diagnoses printed on 1/31/22, included Alzheimer's Disease, subluxation (dislocation) of left hip with absence of left hip joint, and dysphagia (difficulty swallowing). R3's quarterly MDS dated 11/02/22, indicated R3 had severe cognitive impairment. R3 required total dependence for transfers, extensive assist of two staff for bed mobility, dressing, toilet use, personal hygiene. Extensive assist of one staff for locomotion on and off the unit and supervision for eating. During an Observation on 1/27/23, at 10:00 a.m. to 10:30 a.m. R3 remained in bed with her night clothes still on. NA-B and NA-C entered R3's room. They provided morning cares. NAs were in the R3's room for 30 minutes completing cares. NA-B stated R3 required extensive assist of two staff for cares because R3 had behaviors and contractures. NA's indicated no other NA's were on the floor available to answer the call lights. During an interview on 1/27/23, at 10:30 a.m. NA-B and NA-C both explained R3 had not eaten breakfast yet and were not sure when R3 had last eaten or had been provided with a snack. R4's significant change MDS dated 11/30/22 identified R4 had diagnoses that included arthritis, fracture of the right tibia, and dementia. R4 had moderate cognitive impairment. R4 required extensive assist of two staff for bed mobility, transfers, and dressing., Extensive assist of one staff for personal hygiene, and locomotion.	F 725	utilizing direct care per patient day ratios (HPPD) via the payroll software and is compared against local, state, and federal standards; as found on the CMS Nursing Home Compare website and Monarch Healthcare Management intranet. CMS Payroll Based Journal (PBJ) reports will continue to demonstrate past, present, and future compliance. -Those educated, using Monarch Healthcare Management “Open shift staff policy”, included but was not limited to, Administrator, DON, and Scheduler. -In an effort to fill all vacancies, the facility will continue with recruitment and retention efforts to hire and retain their own staff. -In an effort to fill all vacancies, the facility will continue to contract with External Staffing agencies, as defined by the MN Supplemental Nursing Services Agency (SNSA), and Monarch Healthcare Management float pool for temporary staffing needs. -In an effort to fill all vacancies, the facility will continue to offer “bonuses” or monetary incentives to potentially assist with additional shifts being picked up by current staff. -Audits include, but are not limited to, resident and staff interviews, and monitoring call light response time(s) via the -Audits will be completed five (5) times per week for two (2) weeks; three (3) times per week for 4 weeks; weekly for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient	

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F 725	Continued From page 4 During an observation on 1/27/23, at 08:50 a.m. R4 was in the bathroom when nursing assistant (NA)-A entered the room her room to answer the call light. When NA-A asked R4 if she wanted to get dressed for the day, R4 responded "No" she was too tired from sitting on the toilet for so long and wanted to go back to bed. NA-A assisted R4 back to bed. Review of the Call light log dated 1/27/23 identified R4's bathroom call light had been on for one hour and nine minutes. During an interview on 1/31/23 at 10:38 a.m. R4 indicated she could not recall how long she sat on the toilet the morning of 1/27/22, because it happened all the time. R4 felt upset but could never be mad because the staff were always busy and helped her when they had time. Review of the call light log between 1/8/23, at 6:04 a.m. through 1/14/23, at 5:40 a.m. identified 1013 call lights activated; 374 of those were on for greater than 10 minutes. Of those 374 calls lights activated, 23 call lights were on for over an hour the longest being 1 hour 39 minutes. Review of the call light log for 1/22/23, identified 170 call lights activated and 66 of those were greater than ten minutes. Of those 66 calls, eight were activated for over one hour; the longest being two hours 52 minutes. Review of the call light log for 1/27/23 from 12:00 a.m. to 2:50 p.m. there were 109 call lights activated with 29 call lights activated for greater than 10 minutes. Of those 29 call lights activated for over 10 minutes there were two call lights activated, with the longest being two hours and 24 minutes and 17 seconds. During an interview on 1/27/23, at 10:30 a.m. NA-B and NA-C. NA-C indicated she was	F 725	practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 3/16/23	

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F 725	Continued From page 5 contracted agency staff who often worked double shifts. Both stated that they usually work with two NAs on day shift when there should be three NAs. NA-B indicated that they did not have time to chart until the end of the shift; sometimes that meant staying late into the next shift. Both NAs indicated they could not get residents up timely for breakfast. Nursing schedule between 1/8/23 to 1/14/23, 1/22/23 and 1/27/23 were reviewed and identified the following staffing patterns for NAs. -1/8/23, 3 NAs day shift and 2 NAs on evening shift -1/9/23, 1 NA day shift and 2 NAs evening shift -1/10/23, 2 NAs day shift and 2 NAs evening shift -1/11/23, 2 NAs day shift and 2 NAs evening shift. -1/12/23, 2 NAs day shift and 2 NAs evening shift -1/13/23 3 NAs day shift and 2 NAs evening shift -1/14/23 call light log ended at 5:40 a.m. -1/22/23 2 NAs day shift and 2 NAs evening shift -1/27/23 3 NAs day shift and 3 NAs evening shift During an interview on 1/31/23 at 2:24 p.m. NA-A and NA-B. NA-A stated that she felt like there was not enough time to get everything done during the shift. NAs stated there were 16 residents that all needed to getup and dressed for breakfast at 9:00 a.m.; many required two staff assist. Meanwhile there were showers to do and call lights to answer. NA-A stated that we either have to get people up and ignore the call lights or not get people up and answer the call lights. During an interview on 1/27/23 at 3:23 p.m. DON stated an expectation call light were answered in five minutes. DON explained the facility was currently working on call light response times; facility average was 10 minutes. The expectation	F 725		

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F 725	Continued From page 6 was for all staff to answer call lights. Staffing goal included two nurses and three NAs for day shift. Evening shift goal was two nurses and two to three NA's. Night shift was one nurse and two NAs. During an interview on 1/31/23 at 11:34 a.m. Administrator and RN-C, administrator stated the facility did not have a call light policy, but it was the facility's expectation call lights were answered within five minutes. Was not aware of reasoning behind long call light times. Staffing goal for day and evening shift was two nurses and three NA's Staffing policy dated October 2017 included Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		3/16/23

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F 755	Continued From page 7 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available for administration per physician's orders for 3 of 3 residents (R1, R5 and R6) reviewed for medication errors. Findings include: R1's diagnoses list printed on 1/27/23, included nonalcoholic steatohepatitis NASH (liver inflammation and damage caused by a buildup of fat in the liver). R1's adminission minimum data set (MDS) dated 1/12/23, identified R1 was admitted to the facility on 1/5/23. R1's Physician orders included: -Lactulose (a liquid medication used in the treatment of hepatic encephalopathy) 30 milliliters (ml) twice daily with a start date of 1/5/23 -Rifaximin (tablet used to treat hepatic	F 755	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 Administrator 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	

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	245473	A. BUILDING _____ B. WING _____	C 01/31/2023

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 755	Continued From page 8 encephalopathy) 550 milligrams (mg) twice daily with a start date of 1/5/23. R1's January 2023 Medication Administration Record (MAR) Rifaximin and Lactulose doses were not administered according to physician orders on 1/5/23 and 1/6/23; boxes were marked with chart code '9' (other/see nurses notes) Corresponding nurses notes dated 1/5/23 to 1/7/23 included the following: -1/5/23 at 9:04 p.m. Rifaximin 550 mg, new admit, awaiting delivery. -1/5/23 at 9:03 p.m. Lactulose 30 ml, new admit, awaiting delivery. -1/6/23 at 3:01 a.m. family member (FM)-A gave 30ml Lactulose from home supply -1/6/23 at 3:02 a.m. FM-A gave Rifaximin 550 mg from R1's home supply -1/6/23 at 12:42 p.m. Staff spoke to FM-A. FM-A had brought in R1's supply of Rifaximin 550mg. Staff administered the 8:00 a.m. dose at 12:00 p.m. During an interview on 1/27/23 at 12:20 p.m. FM-A stated she received a phone call from R1 on 1/6/23 around midnight stating R1 had not received her doses of Lactulose and Rifaximin scheduled for evening of 1/5/23. FM-A called the facility and was informed by a staff member the medication had not arrived from the pharmacy. FM-A brought R1's home medications into the facility at 2:30 a.m. and gave the Lactulose and Rifaximin to R1 to self-administer. FM-A also had R1 self-administer the Rifaximin again on 1/6/23 at 12:00 p.m. for the 8:00 a.m. dose as mediation had not arrived yet. This happened again on 1/11/23, as the facility did not reorder this medication in a timely manner.	F 755	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 medications are available for administration per physician's orders. -All residents who receive medications have the potential to be affected if this requirement is not met. -R1, R5 and R6 were audited for missing medications to ensure medications were available for administration per physician orders. -Polaris Pharmacy was notified of concern for missing medications upon admit and requested plan for correction. Pharmacy reports to have re educated staff and developed an internal plan to ensure quality and timely delivery. -All residents who receive medications were audited for missing medications to ensure medications were available for administration per physician orders. -The facility completed an Ad Hoc QAPI for pharmacy services and educated necessary staff on the facility's medication administration process, expectations, home medication administration procedure, and medication error	

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F 755	Continued From page 9 During an interview on 1/27/23 at 4:11 p.m. LPN-A stated she was the nurse working on 1/5/23 when the medications did not arrive and had spoken to FM-A about the medications. FM-A brought in the Lactulose and Rifaximin for R1 to self-administer. During an interview on 1/27/23 at 2:35 p.m. DON stated the facility switched pharmacies on 1/5/23 and the delivery person did not know where to take the medications to. R1's medications were found the next day at the attached assisted living complex. DON did not know that the Rifaximin required a pre-authorization prior to delivery. An email communication dated 2/1/23, at 12:11 p.m., MD-A explained R1 has had multiple hospitalizations for hepatic encephalopathy (condition caused by high ammonia levels). R1 should never miss her doses of Rifaximin because the medications help lower her ammonia levels. R5 R5's diagnoses list printed 1/27/23 included fractured right lower leg, acute cystitis (inflammation of the bladder), and eczema (skin disorder). R5's physician orders included: -Triamcinolone Cream (skin cream to treat eczema) 1% apply to affected areas topically two times a day for eczema with a start date of 1/26/23 -Aspirin EC 81mg twice daily for ankle fracture with a start date of 1/26/23 - Eszopiclone (medication used for sleep) 3mg at bedtime with a start date of 1/26/23	F 755	procedure, including physician notification. Staff educated included, but not limited to, TMA's and Licensed Nurses. -Audits of missing medications will be completed weekly for four (4) weeks; and monthly thereafter for two (2) months. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 3/16/23	

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F 755	Continued From page 10 -Cranberry 400 mg 2 tablets at bedtime for urinary prophylaxis/cystitis with a start date of 1/26/23. R5's January 2023, MAR identified aspirin, eszopiclone, and cranberry tablets were not administered according to physician's order on 1/26/23; boxes were marked with chart code '9' (other/see nurses notes). Corresponding nurses notes dated 1/26/23 indicated the medications were not available and awaiting delivery. R6 R6's diagnoses list printed 1/27/23, included chronic and paroxysmal (sudden onset of erratic heart rate begins and then stops on its own) atrial fibrillation. R6's quarterly MDS dated 1/25/23, indicated that R6 received a blood thinner 7 days a week. R6's physician orders printer on 1/27/23, included Eliquis (Apixaban) 2.5 mg tablet by mouth two times a day related to paroxysmal atrial fibrillation with a start date of 11/06/21. R6's December 2022, and January 2023, MAR identified R6 missed 4 doses of Apixaban. On 12/31/22, 1/1/23 an 1/2/23; boxes were marked with chart code '9' (other/see nurses notes) Corresponding nurses notes between 12/30/22 to 1/2/23 identified he following: -12/31/22 at 5:15 p.m. medication reordered from the pharmacy -1/1/23 at 9:18 a.m. medication reordered from pharmacy -1/1/23 at 5:36 p.m. medication not available, pharmacy closed	F 755		

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F 755	Continued From page 11 -1/2/23 at 6:57 p.m. medication was not available. Will pass on to reorder in the morning. During an interview on 1/31/22 at 11:34 a.m. administrator and RN-C, both stated that the facility is still working out the "hiccups" they are having with the new pharmacy. The facility's Medication Administration-General Guideline policy revised December 2019 included: A11 "If a medication with a current active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the mediation cannot be located after further investigation, the pharmacy is contacted, or medication removed from the night box/emergency kit." And B12 " ...Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility."	F 755		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2023

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

Re: State Nursing Home Licensing Orders
Event ID: JVSP11

Dear Administrator:

The above facility was surveyed on January 27, 2023 through January 31, 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	C 01/31/2023

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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 January 27, 2023 and January 31, 2023, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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		

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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H54737637C (MN00090158), H54737978C (MN00090433), and H54738075C (MN00090678) with licensing orders issued at 0800 and 1550. 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 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	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient nursing staff to provide care and services to 4 of 4 residents (R1, R2, R3, R4) in a timely manner who were dependent on staff for activities of daily living and voiced concerns with long call light response times. Findings include: R1's diagnoses list printed on 1/27/23 included nondisplaced fracture of the lateral condyle of the left tibia (located at the top of the large bone in	2 800	Corrected	3/16/23

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2 800	Continued From page 3 lower leg, where it forms the knee-joint with the femur- thigh bone), prepatellar bursitis left knee (an inflammation of the bursa in the front of the kneecap), injury to C6 (cervical (neck) spine), nondisplaced fracture of the upper part of the left humerus (the upper arm bone), nonalcoholic steatohepatitis (liver inflammation and damage caused by a buildup of fat in the liver), traumatic brain injury from a fall, and diabetes. R1's admission Minimum Data Set (MDS) dated 1/12/23, indicated an intact cognition and a need for extensive assist of two staff with bed mobility, transfers, dressing, toileting, and extensive assist of one staff for locomotion, and personal hygiene and total dependent on one person for bathing. During an observation on 1/27/23 at 8:50 a.m. R1 remained in bed in her night clothes with her wraps to her lower legs and brace on left knee. During an observation on 1/27/23 at 9:20 a.m. R1's call light was on, NA-A answered it. Therapy was assisting resident to get up and dressed for the day. NA-A assisted PT with moderate assist to walk R1 to the bathroom and then left the room. During an interview on 1/27/23, at 12:20 p.m. FM-A stated on 1/8/23, R1 sat on the toilet for 2 hours with call light on waiting for someone to help her off. On 1/10/23, R1 laid in her stool for 2 hours while she waited for someone to answer her call light. On 1/12/23, a nurse answered R1's call light, R1 had vomited and needed to go to the bathroom but nurse told R1 that she could not help her and that someone would be in shortly to help her. R1 waited for over an hour for a NA to come in to help her.	2 800		

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2 800	Continued From page 4 Interview on 1/27/23, at 2:50 p.m. R1 stated that she had to wait up to an hour or more for the staff to answer her call light. R1 stated that she has put on her call light when she feels like she has to go to the bathroom, but no one comes to answer her call light and then she is incontinent of urine and stool. R1 has not had any skin concerns but is prone to urinary tract infections. R1 stated that she does not feel safe in the facility. R2 R2's diagnoses listing dated 1/31/23, included diabetes, Cerebrovascular disease with hemiparesis (weakness on one side of the body) and hemiplegia (partial or total paralysis (loss of movement/control) of one side of the body), falls and chronic (long lasting greater than six months) pain. R2's quarterly MDS dated 12/28/22, indicated R2 had moderate cognitive impairment. R2 required extensive assist with two staff for bed mobility, transfers, and toilet use. Extensive assist of one for personal hygiene, locomotion, dressing and bathing. During a continuous observation on 1/27/23 that started at 9:32 a.m. and ended at 9:55 a.m. identified R2's call light had been on for 23 minutes before registered nurse (RN)-A entered R2's room. Review of the Call light log dated 1/27/23 identified R2's call light was activated for 29 minutes and five seconds. During an interview on 1/27/23 at 2:35 p.m. R2 stated it took staff a long time to answer her call light. Waiting for staff for long periods of time upset her and made her feel unsafe. R3	2 800		

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2 800	Continued From page 5 R3's diagnoses printed on 1/31/22, included Alzheimer's Disease, subluxation (dislocation) of left hip with absence of left hip joint, and dysphagia (difficulty swallowing). R3's quarterly MDS dated 11/02/22, indicated R3 had severe cognitive impairment. R3 required total dependence for transfers, extensive assist of two staff for bed mobility, dressing, toilet use, personal hygiene. Extensive assist of one staff for locomotion on and off the unit and supervision for eating. During an Observation on 1/27/23, at 10:00 a.m. to 10:30 a.m. R3 remained in bed with her night clothes still on. NA-B and NA-C entered R3's room. They provided morning cares. NAs were in the R3's room for 30 minutes completing cares. NA-B stated R3 required extensive assist of two staff for cares because R3 had behaviors and contractures. NA's indicated no other NA's were on the floor available to answer the call lights. During an interview on 1/27/23, at 10:30 a.m. NA-B and NA-C both explained R3 had not eaten breakfast yet and were not sure when R3 had last eaten or had been provided with a snack. R4 R4's significant change MDS dated 11/30/22 identified R4 had diagnoses that included arthritis, fracture of the right tibia, and dementia. R4 had moderate cognitive impairment. R4 required extensive assist of two staff for bed mobility, transfers, and dressing., Extensive assist of one staff for personal hygiene, and locomotion. During an observation on 1/27/23, at 08:50 a.m. R4 was in the bathroom when nursing assistant	2 800		

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2 800	Continued From page 6 (NA)-A entered the room her room to answer the call light. When NA-A asked R4 if she wanted to get dressed for the day, R4 responded "No" she was too tired from sitting on the toilet for so long and wanted to go back to bed. NA-A assisted R4 back to bed. Review of the Call light log dated 1/27/23 identified R4's bathroom call light had been on for one hour and nine minutes. During an interview on 1/31/23 at 10:38 a.m. R4 indicated she could not recall how long she sat on the toilet the morning of 1/27/22, because it happened all the time. R4 felt upset but could never be mad because the staff were always busy and helped her when they had time. Review of the call light log between 1/8/23, at 6:04 a.m. through 1/14/23, at 5:40 a.m. identified 1013 call lights activated; 374 of those were on for greater than 10 minutes. Of those 374 calls lights activated, 23 call lights were on for over an hour the longest being 1 hour 39 minutes. Review of the call light log for 1/22/23, identified 170 call lights activated and 66 of those were greater than ten minutes. Of those 66 calls, eight were activated for over one hour; the longest being two hours 52 minutes. Review of the call light log for 1/27/23 from 12:00 a.m. to 2:50 p.m. there were 109 call lights activated with 29 call lights activated for greater than 10 minutes. Of those 29 call lights activated for over 10 minutes there were two call lights activated, with the longest being two hours and 24 minutes and 17 seconds. During an interview on 1/27/23, at 10:30 a.m. NA-B and NA-C. NA-C indicated she was contracted agency staff who often worked double shifts. Both stated that they usually work with two NAs on day shift when there should be three NAs.	2 800		

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	00619	A. BUILDING: _____ B. WING _____	C 01/31/2023

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2 800	Continued From page 7 NA-B indicated that they did not have time to chart until the end of the shift; sometimes that meant staying late into the next shift. Both NAs indicated they could not get residents up timely for breakfast. Nursing schedule between 1/8/23 to 1/14/23, 1/22/23 and 1/27/23 were reviewed and identified the following staffing patters for NAs.F725 SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, medication administration, meals, and eating assistance. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services.	21550		3/16/23

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21550	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available for administration per physician's orders for 3 of 3 residents (R1, R5 and R6) reviewed for medication errors. Findings include: R1's diagnoses list printed on 1/27/23, included nonalcoholic steatohepatitis NASH (liver inflammation and damage caused by a buildup of fat in the liver). R1's adminission minimum data set (MDS) dated 1/12/23, identified R1 was admitted to the facility on 1/5/23. R1's Physician orders included: -Lactulose (a liquid medication used in the treatment of hepatic encephalopathy) 30 milliliters (ml) twice daily with a start date of 1/5/23 -Rifaximin (tablet used to treat hepatic encephalopathy) 550 milligrams (mg) twice daily with a start date of 1/5/23. R1's January 2023 Medication Administration Record (MAR) Rifaximin and Lactulose doses were not administered according to physician orders on 1/5/23 and 1/6/23; boxes were marked with chart code '9' (other/see nurses notes) Corresponding nurses notes dated 1/5/23 to 1/7/23 included the following: -1/5/23 at 9:04 p.m. Rifaximin 550 mg, new admit, awaiting delivery. -1/5/23 at 9:03 p.m. Lactulose 30 ml, new admit, awaiting delivery.	21550	Corrected.	

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21550	Continued From page 9 -1/6/23 at 3:01 a.m. family member (FM)-A gave 30ml Lactulose from home supply -1/6/23 at 3:02 a.m. FM-A gave Rifaximin 550 mg from R1's home supply -1/6/23 at 12:42 p.m. Staff spoke to FM-A. FM-A had brought in R1's supply of Rifaximin 550mg. Staff administered the 8:00 a.m. dose at 12:00 p.m. During an interview on 1/27/23 at 12:20 p.m. FM-A stated she received a phone call from R1 on 1/6/23 around midnight stating R1 had not received her doses of Lactulose and Rifaximin scheduled for evening of 1/5/23. FM-A called the facility and was informed by a staff member the medication had not arrived from the pharmacy. FM-A brought R1's home medications into the facility at 2:30 a.m. and gave the Lactulose and Rifaximin to R1 to self-administer. FM-A also had R1 self-administer the Rifaximin again on 1/6/23 at 12:00 p.m. for the 8:00 a.m. dose as mediation had not arrived yet. This happened again on 1/11/23, as the facility did not reorder this medication in a timely manner. During an interview on 1/27/23 at 4:11 p.m. LPN-A stated she was the nurse working on 1/5/23 when the medications did not arrive and had spoken to FM-A about the medications. FM-A brought in the Lactulose and Rifaximin for R1 to self-administer. During an interview on 1/27/23 at 2:35 p.m. DON stated the facility switched pharmacies on 1/5/23 and the delivery person did not know where to take the medications to. R1's medications were found the next day at the attached assisted living complex. DON did not know that the Rifaximin required a pre-authorization prior to delivery.	21550		

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21550	Continued From page 10 An email communication dated 2/1/23, at 12:11 p.m., MD-A explained R1 has had multiple hospitalizations for hepatic encephalopathy (condition caused by high ammonia levels). R1 should never miss her doses of Rifaximin because the medications help lower her ammonia levels. R5 R5's diagnoses list printed 1/27/23 included fractured right lower leg, acute cystitis (inflammation of the bladder), and eczema (skin disorder). R5's physician orders included: -Triamcinolone Cream (skin cream to treat eczema) 1% apply to affected areas topically two times a day for eczema with a start date of 1/26/23 -Aspirin EC 81mg twice daily for ankle fracture with a start date of 1/26/23 - Eszopiclone (medication used for sleep) 3mg at bedtime with a start date of 1/26/23 -Cranberry 400 mg 2 tablets at bedtime for urinary prophylaxis/cystitis with a start date of 1/26/23. R5's January 2023, MAR identified aspirin, eszopiclone, and cranberry tablets were not administered according to physician's order on 1/26/23; boxes were marked with chart code '9' (other/see nurses notes). Corresponding nurses notes dated 1/26/23 indicated the medications were not available and awaiting delivery. R6 R6's diagnoses list printed 1/27/23, included chronic and paroxysmal (sudden onset of erratic	21550		

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21550	Continued From page 11 heart rate begins and then stops on its own) atrial fibrillation. R6's quarterly MDS dated 1/25/23, indicated that R6 received a blood thinner 7 days a week. R6's physician orders printer on 1/27/23, included Eliquis (Apixaban) 2.5 mg tablet by mouth two times a day related to paroxysmal atrial fibrillation with a start date of 11/06/21. R6's December 2022, and January 2023, MAR identified R6 missed 4 doses of Apixaban. On 12/31/22, 1/1/23 an 1/2/23; boxes were marked with chart code '9' (other/see nurses notes) Corresponding nurses notes between 12/30/22 to 1/2/23 identified he following: -12/31/22 at 5:15 p.m. medication reordered from the pharmacy -1/1/23 at 9:18 a.m. medication reordered from pharmacy -1/1/23 at 5:36 p.m. medication not available, pharmacy closed -1/2/23 at 6:57 p.m. medication was not available. Will pass on to reorder in the morning. During an interview on 1/31/22 at 11:34 a.m. administrator and RN-C, both stated that the facility is still working out the "hiccups" they are having with the new pharmacy. The facility's Medication Administration-General Guideline policy revised December 2019 included: A11 "If a medication with a current active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the mediation cannot be located after further investigation, the pharmacy is contacted, or medication removed	21550		

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21550	Continued From page 12 from the night box/emergency kit." And B12 " ...Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the aquisition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		