Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 7, 2024

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

RE: CCN: 245473
Cycle Start Date: February 5, 2024

Dear Administrator:

On February 5, 2024, 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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 7, 2024

Administrator
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334

Re: Reinspection Results
Event ID: QM6412

Dear Administrator:

On February 5, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 16, 2024. At this time these correction orders were found corrected.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 18, 2024

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

RE: CCN: 245473
Cycle Start Date: January 16, 2024

Dear Administrator:

On January 16, 2024, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 April 16, 2024 (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 16, 2024 (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

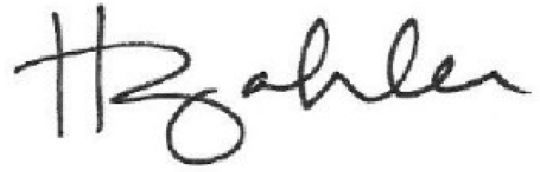
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
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
	245473	A. BUILDING ______ B. WING ______	C 01/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/11/24 and 1/16/24, 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: H54738726C (MN00099772) and H54738729C (MN00099656) with a deficiencies cited at F658 and F880. 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure provider orders	F 658	Please accept the following as the facility's credible allegation of compliance.	2/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/30/2024

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

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F 658	Continued From page 1 for nothing by mouth (NPO)was followed for 1 of 1 (R1) who had outside procedures requiring NPO before appointments resulting in resident missing appointment. Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/29/23, indicated R1 had severe cognitive impairment and diagnosis of cancer, R1's appointment schedule and instructions dated 12/11/23, indicated R1 was scheduled for a nuclear medicine A positron emission tomography (PET) scan (a type of imaging test that uses a radioactive substance called a tracer to look for disease in the body. A PET scan shows how organs and tissues are working.) PET CT scan for 12/28/23, at 9:15 a.m.. Instructions included. -the day before exam for your evening meal do not eat carbohydrates, such as potatoes, rice, pasta, bread, sugar, desserts, or juices. -eat high protein meal. -drink about 48 ounces of water, if possible -12 hours before the exam: Do not use nicotine, caffeine, gum, and mints. On the day of your appointment: Eating and drinking before your exam -8 hours before: stop drinking nutritional supplements. -6 hours before: stop tube feeds. -4 hours before: stop eating or drinking anything but plain water. R1's electronic medication administration record and electronic treatment record (eMAR/eTAR) indicated PET CT SCAN 12/28/23 day before exam: no strenuous activity 24 hours prior to exam. Do not eat carbs. Eat a high protein meal.	F 658	This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: - R1's appointment was rescheduled and the scan was completed on 1/3/2024 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficiency. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility will educate staff on temporary NPO status. Facility will make a process change to review any NPO orders during morning meeting for the next day. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: Facility will audit any NPO orders weekly for 4 weeks. Completion date: 2/2/2024	

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F 658	Continued From page 2	F 658		

One time only for 1 day. Dated 12/27/23. PET CT SCAN: Day of SCAN 12/28/23; 4 hours prior- stop eating and drinking anything except for plain water. One time only for 1 DAY start date 12/28/23. This date signed with a '9' indicating to see nurses notes.

R1's progress note dated 12/28/23, at 8:48 a.m., indicated resident had a scheduled PET scan today and was supposed to be nothing by mouth (NPO.) R2 had eaten an egg and writer called to see if he could still have the procedure done but had to reschedule for 1/3/24 at 7:45 a.m..

R1's progress note dated 1/3/24, at 4:25 p.m., indicated R1 went to appointment for PET scan and returned.

R1's progress note dated 1/8/24, at 12:20 p.m., indicated family member called and requested hospice referral as recent testing indicated cancer to upper and lower spine, pelvis, right shoulder, lungs and lymph nodes, nothing to do now but keep R1 comfortable.

R1's progress note dated 1/11/24, at 8:37 a.m., indicated R1 admitted to hospice.

During an interview on 1/16/24, at 3:26 p.m., nuclear medicine technologist stated a PET SCAN is usually related to oncology. The procedure uses a glucose based radioactive contrast that sugars in the body need to be low in order for it to work properly. We would reschedule an appointment if the patient had consumed anything before the procedure. The medication we would have used for the procedure would be wasted as well. If a patient does not get the procedure done at the appointment time then that

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F 658	Continued From page 3 delays treatment and or surgeries. During an interview on 1/16/24, at 3:58 p.m. DON stated depending on how the facility received the orders, would determine how the orders were transcribed in the medical record and communicated. DON stated when R1 arrived 5 days ago to the facility it was apparent that communication was lacking from the nurses. DON stated he recognized the facility needed a new process for appointments, an appointment book had been started. DON expressed he would expect that all physician orders be followed. NPO should be followed as ordered for resident safety and treatment. A policy for physician orders was requested and not received.	F 658		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		2/2/24

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F 880	Continued From page 4 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 5 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 3 residents (R2) observed during peri care and medication administration. Findings include: R2's significant change Minimum Data Set (MDS) dated 12/29/23, identified R2's diagnoses include debility and dementia. In addition, R2's MDS identified R2 was cognitively impaired and was dependent to max assistance with activities of daily living. R2's care plan dated 12/22/22, indicated R2 has bladder incontinence r/t Alzheimer's, impaired mobility, loss of peritoneal tone, irritant contact dermatitis do to incontinence, history of recurrent urinary tract infections (UTI) with known diverticula with history of fistula with bladder. Goal for resident to remain free from s/sx of UTI. During an observation on 1/11/24 at 12:44 p.m., nursing assistant (NA)-A entered R2's room pushing the wheelchair with R2 in it. NA-A did not wash or sanitize hands upon entering the room and grabbed a mattress protector and placed it on R2's bed. NA-A then took the pedals off R2's	F 880	Please accept the following as the facility's credible allegation of compliance. This plan of Correction does not constitute any admission of guild or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: - The facility assessed R2 for signs and symptoms of infection after the alleged break in infection control with no adverse outcomes. How will the facility identify other residents having the potential to be affected by the same deficient practice? - All residents have the potential to be affected by the alleged deficiency. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: - The facility will re-educate staff on hand hygiene. The facility will perform weekly audits of handwashing times 4 weeks.	

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F 880	Continued From page 6 wheelchair, and started water in the sink. NA-A then grabbed a bedpan and some clean cloths and filled the bed pan with water. NA-A grabbed the bed pan and the cloths and moved from bathroom into the bed area. NA-A then took items off the bedside table to make room for the bed pan. NA-A grabbed a tissue put on gloves and wiped R2's nose. NA-A then took off the gloves and threw away the gloves and the used tissue, then put on new gloves without sanitizing or cleaning hands. Trained medical assistant (TMA)-A entered the room without sanitizing put on gloves and assisted to put the transfer sling around R2, using the same gloves grabbed the cup of water and medication and spoon fed medications to R2. TMA-A then put remaining medication down on bed side table. TMA-A and NA-A then assisted R2 into bed and completed peri cares with gloves on . NA-A removed R2's dirty brief and TMA-A assisted in rolling R2 Pushing the dirty brief under R2 and pulling clean brief underneath her simultaneously.. NA-A applied barrier cream with same gloves on. TMA-A removed her gloves proceeded to give oral medication to R2 without washing or sanitizing hands. During interview on 1/11/24, at 1:04 p.m., TMA-A stated she should have washed or sanitized her hands when entering and or leaving a resident's room. TMA-A reported she should have sanitized or wash hands during cares or whenever she changed her gloves. TMA-A verified she had not appropriately sanitized or washed hands during R2's, "it just slipped her mind", because she usually did not help with resident cares. During an interview on 1/11/2024, at 1:10 p.m., NA-A stated she should have sanitized her hands	F 880	Quality Assurance plnas to monitor facility performance to make sure that corrections are achieved and are permanent: - Facility will reivew the audits as part of monthly QAPI Completion date 2/2/2024	

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F 880	Continued From page 7	F 880		

more during R2's cares. NA-A was unable to articulate why she had not sanitized her hands appropriately but stated she wasn't sure if she was able to use the sink in the resident's rooms to wash her hands. NA-A verified she did not change her gloves each time she moved from a dirty area to a clean area and did not perform hand hygiene between any of the glove changes.

During an interview on 1/16/24 at 3:58 p.m., the director of nursing (DON) stated it was an expectation staff should "foam in" and "foam out" when entering residents' rooms, wear gloves whenever providing incontinent cares, and change them each time they moved from a dirty area to a clean area. DON further stated staff were expected to perform hand hygiene with each glove change. The DON expressed all staff are expected to follow facility policy when it came to hand hygiene and infection control.

The policy Handwashing/Hand Hygiene revised 8/2019, indicated the facility considers hand hygiene the primary means to prevent the spread of infections. The policy directed all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or
non-antimicrobial) and water for the following situations:
-before and after coming in direct contact with a resident
-before moving from a contaminated body site to a clean body site during resident care
-after contact with blood or bodily fluids
-before preparing or handling medications

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F 880	Continued From page 8 -after contact with a resident's intact skin -after contact with objects(e.g.medical equipment) in the immediate vicinity of the resident -after removing gloves	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: QM6411

Dear Administrator:

The above facility was surveyed on January 11, 2024 through January 16, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

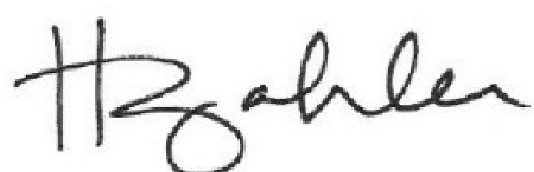
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

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
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

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 01/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****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 1/11/24 and 1/16/24, 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 when they will be completed.

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2 000	Continued From page 1 The following complaints were reviewed: H54738726C (MN00099772) and H54738729C (MN00099656) with licensing orders issued at 0830 and 1390. 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 state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure provider orders for nothing by mouth (NPO)was followed for 1 of 1 (R1) who had outside procedures requiring NPO before appointments resulting in resident missing appointment. Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/29/23, indicated R1 had severe cognitive impairment and diagnoses of cancer,	2 830	Corrected	2/2/24

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2 830	Continued From page 3 R1's appointment schedule and instructions dated 12/11/23, indicated R1 was scheduled for a nuclear medicine A positron emission tomography (PET) scan (a type of imaging test that uses a radioactive substance called a tracer to look for disease in the body. A PET scan shows how organs and tissues are working.) PET CT scan for 12/28/23, at 9:15 a.m.. Instructions included. -the day before exam for your evening meal do not eat carbohydrates, such as potatoes, rice, pasta, bread, sugar, desserts, or juices. -eat high protein meal. -drink about 48 ounces of water, if possible -12 hours before the exam: Do not use nicotine, caffeine, gum, and mints. On the day of your appointment: Eating and drinking before your exam -8 hours before: stop drinking nutritional supplements. -6 hours before: stop tube feeds. -4 hours before: stop eating or drinking anything but plain water. R1's electronic medication administration record and electronic treatment record (eMAR/eTAR) indicated PET CT SCAN 12/28/23 day before exam: no strenuous activity 24 hours prior to exam. Do not eat carbs. Eat a high protein meal. One time only for 1 day. Dated 12/27/23. PET CT SCAN: Day of SCAN 12/28/23; 4 hours prior-stop eating and drinking anything except for plain water. One time only for 1 DAY start date 12/28/23. This date signed with a '9' indicating to see nurses notes. R1's progress note dated 12/28/23, at 8:48 a.m., indicated resident had a scheduled PET scan today and was supposed to be nothing by mouth (NPO.) R2 had eaten an egg and writer called to see if he could still have the procedure done but	2 830		

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2 830	Continued From page 4 had to reschedule for 1/3/24 at 7:45 a.m.. R1's progress note dated 1/3/24, at 4:25 p.m., indicated R1 went to appointment for PET scan and returned. R1's progress note dated 1/8/24, at 12:20 p.m., indicated family member called and requested hospice referral as recent testing indicated cancer to upper and lower spine, pelvis, right shoulder, lungs and lymph nodes, nothing to do now but keep R1 comfortable. R1's progress note dated 1/11/24, at 8:37 a.m., indicated R1 admitted to hospice. During an interview on 1/16/24, at 3:26 p.m., nuclear medicine technologist stated a PET SCAN is usually related to oncology. The procedure uses a glucose based radioactive contrast that sugars in the body need to be low in order for it to work properly. We would reschedule an appointment if the patient had consumed anything before the procedure. The medication we would have used for the procedure would be wasted as well. If a patient does not get the procedure done at the appointment time then that delays treatment and or surgeries. During an interview on 1/16/24, at 3:58 p.m. DON stated depending on how the facility received the orders, would determine how the orders were transcribed in the medical record and communicated. DON stated when R1 arrived 5 days ago to the facility it was apparent that communication was lacking from the nurses. DON stated he recognized the facility needed a new process for appointments, an appointment book had been started. DON expressed he would expect that all physician orders be followed. NPO	2 830		

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2 830	Continued From page 5 should be followed as ordered for resident safety and treatment. A policy for physician orders was requested and not received. SUGGESTED METHOD OF CORRECTION: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize medication errors, missed treatments, and improved communication, for residents at risk to assure they are receiving the necessary treatment/s. The director of nursing or designee, could conduct random audits of physician orders; to ensure appropriate care and services are implementented, TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;	21390		2/2/24

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21390	Continued From page 6	21390		

F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;
G. a system for reviewing antibiotic use;
H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and
I. methods for maintaining awareness of current standards of practice in infection control.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 3 residents (R2) observed during peri care and medication administration.

Corrected

Findings include:

R2's significant change Minimum Data Set (MDS) dated 12/29/23, identified R2's diagnoses include debility and dementia. In addition, R2's MDS identified R2 was cognitively impaired and was dependent to max assistance with activities of daily living.

R2's care plan dated 12/22/22, indicated R2 has bladder incontinence r/t Alzheimer's, impaired mobility, loss of peritoneal tone, irritant contact dermatitis do to incontinence, history of recurrent urinary tract infections (UTI) with known diverticula with history of fistula with bladder. Goal for resident to remain free from s/sx of UTI.

During an observation on 1/11/24 at 12:44 p.m., nursing assistant (NA)-A entered R2's room

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21390	Continued From page 7 pushing the wheelchair with R2 in it. NA-A did not wash or sanitize hands upon entering the room and grabbed a mattress protector and placed it on R2's bed. NA-A then took the pedals off R2's wheelchair, and started water in the sink. NA-A then grabbed a bedpan and some clean cloths and filled the bed pan with water. NA-A grabbed the bed pan and the cloths and moved from bathroom into the bed area. NA-A then took items off the bedside table to make room for the bed pan. NA-A grabbed a tissue put on gloves and wiped R2's nose. NA-A then took off the gloves and threw away the gloves and the used tissue, then put on new gloves without sanitizing or cleaning hands. Trained medical assistant (TMA)-A entered the room without sanitizing put on gloves and assisted to put the transfer sling around R2, using the same gloves grabbed the cup of water and medication and spoon fed medications to R2. TMA-A then put remaining medication down on bed side table. TMA-A and NA-A then assisted R2 into bed and completed peri cares with gloves on . NA-A removed R2's dirty brief and TMA-A assisted in rolling R2 Pushing the dirty brief under R2 and pulling clean brief underneath her simultaneously.. NA-A applied barrier cream with same gloves on. TMA-A removed her gloves proceeded to give oral medication to R2 without washing or sanitizing hands. During interview on 1/11/24, at 1:04 p.m., TMA-A stated she should have washed or sanitized her hands when entering and or leaving a resident's room. TMA-A reported she should have sanitized or wash hands during cares or whenever she changed her gloves. TMA-A verified she had not appropriately sanitized or washed hands during R2's, "it just slipped her mind", because she usually did not help with resident cares.	21390		

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21390	Continued From page 8	21390		

During an interview on 1/11/2024, at 1:10 p.m., NA-A stated she should have sanitized her hands more during R2's cares. NA-A was unable to articulate why she had not sanitized her hands appropriately but stated she wasn't sure if she was able to use the sink in the resident's rooms to wash her hands. NA-A verified she did not change her gloves each time she moved from a dirty area to a clean area and did not perform hand hygiene between any of the glove changes.

During an interview on 1/16/24 at 3:58 p.m., the director of nursing (DON) stated it was an expectation staff should "foam in" and "foam out" when entering residents' rooms, wear gloves whenever providing incontinent cares, and change them each time they moved from a dirty area to a clean area. DON further stated staff were expected to perform hand hygiene with each glove change. The DON expressed all staff are expected to follow facility policy when it came to hand hygiene and infection control.

The policy Handwashing/Hand Hygiene revised 8/2019, indicated the facility considers hand hygiene the primary means to prevent the spread of infections. The policy directed all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:
-before and after coming in direct contact with a resident
-before moving from a contaminated body site to a clean body site during resident care

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21390	Continued From page 9	21390		

-after contact with blood or bodily fluids
-before preparing or handling medications
-after contact with a resident's intact skin
-after contact with objects(e.g.medical equipment) in the immediate vicinity of the resident
-after removing gloves

SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.

Time Period for Correction: Twenty-one (21) days.