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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Manor LLC	640 Third Street Gaylord, MN 55334

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to convey a resident's most current Provider Order for Life Sustaining Treatment (POLST) form to the receiving provider when 1 of 1 resident (R1) was transferred to the emergency department (ED), reviewed for discharge. Findings include: R1's POLST dated [DATE], identified Section A: if R1 has no pulse and is not breathing do not attempt resuscitation. Section B: Comfort-Focused Treatment (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to the hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Section C: R1's documentation of discussion and was signed by R1. Section D: signed by certified nurse practitioner and dated [DATE]. Section E: additional preferences- no artificial nutrition by tube, no antibiotics, use other methods to relieve symptoms when possible. R1's care plan dated [DATE], identified a focus of current code status; see POLST. Interventions included an advanced Directive in place and will be honored during the review period, arrange MD consultation as necessary, assess resident for ability to cope with information provided, review resident's Advance Directive PRN per resident and/or family request and staff to follow POLST guidelines. R1's POLST dated [DATE], identified Section A: if R1 has no pulse and is not breathing do not attempt resuscitation. Section B: Comfort-Focused Treatment (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to the hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Section C: R1's documentation of discussion and was signed by R1. Section D: signed by certified nurse practioner and dated [DATE]. Section E: additional preferences- no artificial nutrition by tube, no antibiotics, use IV/IM antibiotics. R1's order summary dated [DATE] identified R1 was Do Not Resuscitate (DNR). R1's admission Minimum Data Set (MDS) dated [DATE], identified that R1 had moderately impaired cognition and diagnoses included paranoid schizophrenia, unspecified intellectual disabilities and diabetes mellites. (continued on next page)

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.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 nursing progress note dated [DATE] at 6:43 p.m., R1 was sent to hospital per care coordinators and provider - R1 had been refusing all cares and being aggressive towards staff. R1's ED to hospital admission documents dated [DATE], R1's hospital course identified had chronic cognitive impairment, paranoid schizophrenia, type 2 diabetes insulin-dependent, lower extremity lymphedema, presented from facility via EMS due to increased confusion, agitation and refusal of cares. Review of R1's POLST shows comfort measures only, DNR DNI and no antibiotics. Was able to discuss case with R1's family he does not have a court appointed guardian as he has remained his own guardian. Review of the POLST was that it was signed by R1. It stated that he does not wish to have any antibiotics including oral and wants comfort measures only. After discussion with family, she reported that we should follow the POLST recommendations as that would be his wishes. R1 was admitted for possible right lower lobe pneumonia and left lower extremity cellulitis. Given R1's wishes noted on previous POLST signed on [DATE], that R1 would not wish to have any antibiotics including oral antibiotics and comfort measures only. This was confirmed with R1's family member. Based on this R1 will plan to discharge back to his facility possibly on hospice. R1's Discharge summary dated [DATE], identified R1 was discharged with the plan to initiate hospice based on the initial POLST form from 2023. However, with the new information and further conversation with R1 at his skilled nursing facility hospice has not been initiated. Given that R1 was hemodynamically stable, afebrile, not requiring supplemental oxygen it was reasonable that R1 was discharged on oral antibiotics with close outpatient follow-up with primary care provider. Therefore, R1 will be discharged on a course of Augmentin for presumptive right lower lobe pneumonia. R1 should return to the emergency room if he has worsening symptoms or concern for clinical decline. Otherwise recommend follow-up with primary care provider in 1 to 2 days. R1's progress note dated [DATE] at 1:59 p.m., At 3:15 p.m., R1 was sent back to the facility from the hospital with a diagnosis of pneumonia. During an interview on [DATE] at 3:25 p.m., R1 was seated in his wheelchair in the hallway. R1 stated he was in hospital a couple weeks ago because he was out of his diet mountain dew, and he got dehydrated. R1 stated he thought he had an infection somewhere but really couldn't remember. During an interview on [DATE] at 10:56 a.m., licensed practical nurse care coordinator (LPNCC)-A stated she worked on [DATE], and R1 was not himself that day had been refusing cares for several hours and was combative with staff. LPNCC-A stated they did get an order form a provider to send R1 to the ED. LPNCC-A further stated she printed out his face sheet and his medication administration record, for the nurse that would be sending R1 out. LPNCC-A stated she did not print R1's POLST. LPNCC-A stated she had left the building before R1 was sent to the ED, so she was unsure if R1's most recent POLST was printed and sent with. During a phone interview on [DATE] at 1:17 p.m., licensed practical nurse (LPN)-A stated he worked on [DATE], and was the nurse responsible for R1. LPN-A stated he did not print out any additional forms to send with R1 to the ED. LPN-A verified he did not print out R1's most recent POLST to send with to the ED. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:33 p.m., nurse manager (NM)-A stated when a resident is sent to the hospital emergently the following forms should be sent with; the face sheet, order summary, medication administration record and a current POLST form. NM-A stated all the forms should be handed to ambulance person. During an interview on [DATE] at 1:37 p.m., regional nurse consultant (RNC)-A stated the process for sending a resident to the ED, was to have a provider order and send the following forms with the resident: face sheet, order summary, medication administration record and a current POLST form. RNC-A stated it looked like R1's POLST did not get sent with him to the hospital, so the hospital had R1's old POLST that identified R1 was not to receive antibiotics. RNC-A stated they are in the process of educating all nursing staff on what forms are to be sent with residents during an emergent transfer to ensure the receiving provider can honor resident wishes. Advanced directive policy requested and not received. Emergency transfer document requested and not received. Facility policy, POLST Documentation Procedure, dated 4/2025, identified a purpose to identify a code status consistent with resident wishes and to facilitate providing emergency care and services in accordance with the resident's plan of care. The Resident and/or Resident Representative's decision will be entered into the individualized plan of care/electronic medical record, and will be communicated throughout the facility, so that staff know immediately what action to take or not take when an emergency arises. 1. Resident's and/or Resident Representative's wishes will be discussed and verified by referring to the discharge orders. 2. If the resident's or resident representative's wishes no longer align with the discharge orders, a physician's order must be obtained immediately to support these modified wishes. 3. The physician order should be placed into Point Click Care per the following process.' o When indicating the Code Status of choice, please utilize the standardized abbreviation of DNR or CPR which is located in the Monarch admission Order Sets. o Advance Directive status should be listed as Current and Verified before completing and saving the new order entry. o Order type should be Advanced Directive. 4. Code Status will be reflected in multiple areas within the electronic medical record. This includes Care Profile section located under residents' picture in Point Click Care and Point of Care, and on the MAR/TAR. 5. In the event of an interruption of the electronic health record, refer to the MAR backup software to verify code status. 6. POLST should be uploaded in PCC documents/Misc. tabs. pending signature from Physician/NP and entered POLST (Unsigned). 7. Upload the signed POLST and the unsigned POLST will be deleted out of PCC. The paper POLST will be shredded after uploading. Current POLST that is uploaded, should have verbiage CURRENT POLST. If there are any other POLSTS uploaded into the Documents/Misc., these POLSTS should remain listed and named VOID POLST. 8. A routine audit of the POLST documentation should be completed to ensure consistent and accurate documentation of the POLST form, physician orders, the care plan and entry in PCC.