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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 160E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00776

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245225**

2. STATE VENDOR OR MEDICAID NO. (L2) **685740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SLEEPY EYE CARE CENTER**
(L4) **1105 3RD AVENUE SOUTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/14/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 12/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/04/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **12/01/1978** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245225

November 29, 2017

Ms. Mary Boyde, Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

Dear Ms. Boyde:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 23, 2017 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

Electronically delivered

December 4, 2017

Ms. Mary Boyde, Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

RE: Project Numbers S5225027, F5225027

Dear Ms. Boyde:

On August 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 3, 2017. This survey found the most serious deficiencies 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) whereby corrections were required.

On August 23, 2017 a survey team representing the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. The FMS found the most serious deficiencies to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F).

On September 6, 2017, CMS informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 3, 2017. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of September 6, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 3, 2017.

On September 14, 2017, the Minnesota Department of Health and on October 24, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 3, 2017 and the FMS survey completed on August 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 23, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 3, 2017 and the FMS of August 23, 2017 as of September 23, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in their letter of September 6, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of the action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 3, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 3, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 3, 2017, is to be rescinded.

In the CMS letter of September 6, 2017, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 3, 2017 due to denial of payment for new admissions. Since your facility attained substantial compliance, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 160E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00776

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2. STATE VENDOR OR MEDICAID NO. (L2) **685740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SLEEPY EYE CARE CENTER**
(L4) **1105 3RD AVENUE SOUTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/03/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 08/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/22/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
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25. LTC EXTENSION DATE: (L27)

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A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

August 18, 2017

Ms. Mary Boyde, Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

RE: Project Number S5225027

Dear Ms. Boyde:

On August 3, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 12, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 3, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(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 July 31, August 1, 2, & 3, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for	F 279		9/12/17

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

Electronically Signed | 08/25/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(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 279	Continued From page 1	F 279		

each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(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 279	Continued From page 2 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was developed related to a skin condition for 1 of 3 resident (R94) who was reviewed for a non pressure related skin issue. Findings include: R94's face sheet, dated 6/21/17 identified diagnosis of local infection of the skin and subcutaneous tissue. R94's 14 day PPS Minimum Data Set (MDS) assessment dated 7/4/17, identified a Brief Interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. R94's section M skin conditions identified applications of ointments/medications other than to feet. R94's physician orders dated 8/3/17, identified orders for CeraVe Cream (a moisturizing cream) applied to bilateral legs and arms topically two times a day (BID) for dry/flaky skin. May keep at bedside. R94's physician orders also identified orders for Triamcinolone Acetonide Cream 0.1% (TMC a corticosteroid used to reduce swelling, redness, itching, and allergic reactions) BID on Sunday, Monday, Tuesday, Thursday and Friday. The cream was to be applied to active areas on arms, legs and trunk. R94's care plan last revised 7/7/17, identified	F 279	It is the policy of the Sleepy Eye Care Center to maintain all resident assessments completed within the previous 15 months in the resident□s record and use the results of the assessments to develop, review and revise the resident□s care plan. Resident #94 Based on resident assessment, the resident□s care plan has been reviewed and revised to address resident□s skin issue. Care plan reviewed by interdisciplinary team. For all residents who were assessed with non-pressure skin conditions, care plans were reviewed and revised as needed. Weekly skin Audits will be completed on bath day. Policy and procedures for Skin Assessments, Weekly Skin Audits and Care Planning were reviewed and revised as needed. Nursing Staff will be educated on Skin assessments, Skin Audits, Care Planning Documentation. DON/Designee will review Care Plans for	

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F 279	Continued From page 3 R94's right hip incision but did not identify any other skin issues or use of medications/ointments. During observation on 7/31/17, at 5:53 p.m. R94 was observed to have a bright red raised area on the right side of her face that extended from ear to jaw line. Two small areas that appeared open were noted one below the ear lobe and one above the jaw line. Bright red raised patches were observed on both of R94's arms. R94 stated the red/raised areas were all over and itched like crazy. During observation on 8/2/17, at 7:25 a.m. the right side of R94's face remained bright red raised from ear to jaw. The two open areas appeared to be scabbed over. R94 continued to have bright red raised patches on hands and arms. During observation on 8/3/17, at 9:30 a.m. the right side of R94's face continued to have bright red raised area. The area extended from the ear to R94's neck at that time. Areas of flaky skin were also noted on the right side of R94's face. R94's left side of neck was very bright red and raised and R94's arms continued to have bright red raised areas. R94 complained that areas itched badly. She stated cream was applied to the areas for the first time the previous evening. During interview on 8/3/17, at 9:45 a.m. nursing assistant (NA)-E stated we put lotion on her arms and legs. We just use the house lotion like we do on everyone else. NA-E stated she did not know what the nurses put on her. During interview on 8/2/17, at 12:57 p.m. licensed	F 279	residents with skin conditions weekly for one month. An audit will be performed by the Interdisciplinary team biweekly on 10% of residents to ensure that skin conditions are on the assessments and are care planned. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017.	

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F 279	Continued From page 4 practical nurse (LPN)-B stated R94 had CeraVe cream at bedside for use on arms and legs and also had an order for TMC BID on specific areas. He stated it goes to any of the affected areas. During interview on 8/3/17, at 11:07 a.m. the director of nursing (DON) verified the care plan did not address R94's skin issue and stated it should address the skin issue.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R19, R40) reviewed for activities of daily living (ADL's) was provided assistance with grooming in accordance with the care plan. Findings include: R19 had been observed on 8/1/17, at 9:43 a.m. seated in a wheelchair in room with long soiled fingernails. R19's quarterly Minimum Data Set (MDS) assessment dated 5/25/17, included a brief interview for mental status (BIMS) score of 9 indicating moderate cognitive impairment. The	F 282	It is the policy of the Sleepy Eye Care Center that the services provided or arranged by the facility, as outlined by the comprehensive are plan, must be provided by qualified persons in accordance with each resident□s written plan of care. All residents ADL Care Plans were reviewed and revised as needed. Policy and procedure for Shaving and Nail Care were reviewed and revised as needed. Resident #19	9/12/17

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F 282	Continued From page 5 MDS also indicated R19 required extensive assistance from staff with bed mobility, transfer, toilet use, personal hygiene, and dressing. The care plan last reviewed 6/20/17, indicated R19 required physical assist of one staff with dressing and personal hygiene. Review of the point of care tasks by nursing assistants for R19 included: Nails cleaned and trimmed by nursing assistant. R19's electronic health care record indicated this task was last completed on 7/27/17. On 8/2/17, at 8:40 a.m. nursing assistant (NA)-C was observed providing morning cares for R19; R19's fingernails continued to be long with black debris underneath the nails. During the observation NA-C did not provide nail care for R19. On 8/3/17, at 9:29 a.m. R19 was observed lying in bed with a hospital gown on. R19's fingernails continued to be long and soiled. At 9:32 a.m. NA-A entered R19's room and confirmed she would be providing morning cares for the resident prior to taking to breakfast. At 9:45 a.m. NA-A was observed propelling R19 out of room in a wheelchair; the resident was dressed for the day. R19's fingernails were observed and continued to be long and soiled. NA-A positioned R19 outside of room in hall 3 then was observed to enter another resident's room. At 9:49 a.m., the director of nursing (DON) and surveyor observed R19's fingernails. DON confirmed R19's fingernails were soiled and needed to be trimmed. DON advised the resident that she would clean and trim the fingernails after breakfast. When interviewed on 8/3/17, at 1:04 p.m. the	F 282	Nails were trimmed and cleaned on August 6th, 2017. Resident # 40 Face was shaved on August 7th, 2017. All residents ADL Care Plans were reviewed and revised as needed. Policy and procedure for Shaving and Nail Care were reviewed and revised as needed. Nursing Staff will be educated on Sept 5th, 2017 on removing female and male facial hair with morning cares and to do nail care on residents on bath day and as needed. Routine audits for removal of facial hair and nail care to be completed on all residents weekly x4 weeks. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017.	

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DON verified nail care should be performed weekly with the resident's bath and in between if soiled.
R40's diagnosis sheet, dated 8/3/17 identified a diagnosis of sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) due to cholangitis (an infection of the bile ducts.)

R40's admission Minimum Data Set (MDS), dated 5/4/17 identified a Brief Interview for Mental Status (BIMS) score of 14 indicative of intact cognition. R40's MDS also indicated R40 needed extensive assistance with grooming.

R40's Care Area Assessment (CAA) for ADL's dated 5/4/17 indicated R40 required one staff assistance with ADLS. See care plan for specific interventions.

R40's care plan, revised 7/30/17 indicated R40 required assistance of one staff member with personal hygiene.

During observation on 7/31/17, at 3:14 p.m. R40 was observed sitting in her recliner. R40 was observed to have numerous 1/4 inch long hair along chin/jaw line.

During observation on 8/2/17, at 1:08 p.m. R40 was observed sitting in recliner. R94 continued to have 1/4 inch hair along her chin/jaw line. R94 rubbed the hair and stated well I can't see good enough to do it myself so they are supposed to do it. She stated I need that done but I can't do it myself.

During interview on 8/2/17, at 1:28 p.m. nursing assistant (NA) E verified the presence of R94's

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F 282	Continued From page 7 chin hair. She stated it should be shaved and if the resident does not have a razor the facility had disposable ones for their use. During interview with the director of nursing on 8/3/17, at 11:00 a.m. she stated grooming including shaving should be provided as per the care plan. A policy regarding grooming was requested but none was provided.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		9/12/17

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F 309	Continued From page 8 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor a non pressure related skin condition for 1 of 3 resident (R94) and failed to identify and monitor a laceration obtained during a fall for 1 of 3 resident (R40) who were reviewed for non pressure related skin conditions. Findings include: R94's face sheet, dated 6/21/17, identified diagnosis of local infection of the skin and subcutaneous tissue. R94's 14 day PPS Minimum Data Set (MDS) assessment dated 7/4/17, identified a Brief Interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. R94's section M skin conditions identified applications of ointments/medications other than to feet. R94's physician orders dated 8/3/17, identified an order dated 8/1/17 for CeraVe Cream (a moisturizing cream) applied to bilateral legs and arms topically two times a day (BID) for dry/flaky skin. May keep at bedside. R94's physician orders also identified an order dated 6/21/17 for	F 309	It is the policy of the Sleepy Eye Care Center that each resident receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident□s comprehensive assessment and plan of care. Resident #94 Resident was seen at SEMC on 8/2/2017 for rash. Medication was ordered and rash is clearing. Resident #40 Face is healed at this time. All residents Care Plans with skin conditions were reviewed and revised as needed. Policy and Procedures on Change of Condition were reviewed and revised as needed. Policy and Procedures on Incident/Fall Documentation and follow-up were reviewed and revised as needed.	

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F 309	Continued From page 9 Triamcinolone Acetonide Cream 0.1% (a corticosteroid used to reduce swelling, redness, itching, and allergic reactions) BID on Sunday, Monday, Tuesday, Thursday and Friday. The cream was to be applied to active areas on arms, legs and trunk. R 94's admission skin/Braden assessment dated 6/21/17 did not identify any type of rash. R94's care plan last revised 7/7/17, identified R94 was at risk for impaired skin integrity related to right hip incision. Interventions included weekly wound progress assessment/documentation by nurse, pressure reducing device for bed and chair, weekly skin assessment by licensed nurse and moisturize skin daily. During observation on 7/31/17, at 5:53 p.m. R94 was observed to have a bright red raised area on the right side of her face that extended from ear to jaw line. Two small areas that appeared open were noted one below the ear lobe and one above the jaw line. Bright red raised patches were observed on both of R94's arms. R94 stated the red/raised areas were all over and itched like crazy. During observation on 8/2/17, at 7:25 a.m. the right side of R94's face remained bright red raised from ear to jaw. The two open areas appeared to be scabbed over. R94 continued to have bright red raised patches on hands and arms. R94 stated they are supposed to put lotion on but they never do I always have to ask. R94 stated the Monday before she fell and broke her hip she had a breakout of these red areas. She stated it was so bad I went to the emergency room. She stated they sent her to a	F 309	IDT will review residents for Condition Changes in Daily Stand-Up Meetings. The DON/Designee will review progress notes for change of condition weekly for one month. Nursing Staff will be educated on Sept 5th, 2017 on charting changes in resident□s condition and notifying physician if necessary. Also to document any injuries from a fall on incident report and to set up treatment if necessary. A routine audit will be performed by the Interdisciplinary Team weekly on 10% of residents to ensure that any changes in residents□ condition or injuries are documented, physician notified and treatment set up if needed. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017.	

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dermatologist immediately and was given creams and pills for the rash. R94 also stated if I could take proper care of it and get the cream when I need it. R94 stated I know they get carried away and don't have time to keep up with everything.

During observation on 8/3/17, at 9:30 a.m. the right side of R94's face continued to have bright red raised area. The area extended from the ear to R94's neck at this time. Areas of flaky skin were also noted on the right side of R94's face. R94's left side of neck was very bright red and raised and R94's arms continued to have bright red raised areas. R94 complained that areas itched badly. She stated cream was applied to the areas for the first time the previous evening.

During interview with R94 on 8/3/17 at 2:30 p.m. she stated she was going to the doctor to be checked out. She stated I guess they figure its bad again, I mean look at it. She stated it was bad when she came in, got some better and was now bad again. She stated I guess they are going to see about different medication. Maybe that is why they were kind of holding off on putting that medication on me before. They didn't do it too much.

During interview with family member (FM)-A on 8/3/17, at 2:42 p.m. FM-A was to take R94 to the appointment. FM-A stated it was really bad in the hospital and when she came to the facility she still had the rash and was supposed to be receiving the creams.

During interview on 8/3/17, at 9:45 a.m. nursing assistant (NA)-E she stated we put lotion on her arms and legs. We just use the house lotion like we do on everyone else. NA E stated she did not

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know what the nurses put on her reddened skin.

During interview on 8/2/17, at 12:57 p.m. licensed practical nurse (LPN)-B stated R94 had CeraVe cream at bedside for use on arms and legs and also had an order for Triamcinolone Acetonide Cream twice daily, on specific areas. He stated it goes to any of the affected areas.

During interview on 8/3/17, at 2:04 p.m. NA-D stated when R94 came to the facility she had the rash really bad on her legs, arms and all over. She stated it got better and kind of faded but now its bad again, on her arms and face and neck.

During interview on 8/3/17, at 11:07 a.m. the director of nursing (DON) observed R94 sitting in the dining room. R94 was scratching at her face where it was reddened. The DON stated R94 should be seen by a physician for the rash and stated we will set something up.

R40's diagnosis sheet, dated 8/3/17 identified a diagnosis of sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) due to cholangitis (an infection of the bile ducts.)

On 7/31/17, at 3:24 p.m. R40 was observed sitting in recliner in room. R40 was noted to have an approximate 1 inch dark red crescent shaped scabbed area to right side of face just above jaw line. R40 stated the scabbed area was from her fall.

On 8/3/17, at 12:17 p.m. R40 was observed in recliner in room. R40 continued to have the approximate 1 inch dark red crescent shaped

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scabbed area to right side of face just above jaw line. R40 stated she did not know what she hit it on but it was when she fell. She stated it bled all over.

R40's admission Minimum Data Set (MDS), dated 5/4/17 identified a Brief Interview for Mental Status (BIMS) score of 14 indicative of intact cognition.

R40's incident review dated 7/26/17, identified R40 had a fall on 7/26/17, at 10:50 a.m. The incident identified R40 was being ambulated by staff with walker and gait belt. R40 was near the recliner and could not walk any farther. R40 was lowered to the floor by staff. The report identified R40 was not injured during the fall.

R40's progress notes were reviewed. No documentation was found regarding an area to the right side of R40's face where injury had been found.

During interview on 8/2/17, at 1:28 p.m. nursing assistant (NA)-E stated R40 had gotten the area (cut) on her face when she fell.

During interview on 8/2/17, at 1:30 p.m. registered nurse (RN)-B stated R40 had a fall but had no injuries. Surveyor showed RN-B the area on R40's face. RN B stated, "Oh Ya!" she got that when she fell but that's not really an injury like a fracture or something. He stated he did not know where R40 hit it or how it happened when she fell.

During interview on 8/3/17, at 11:30 a.m. the director of nursing stated the area to R40's face should have been documented on the incident

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F 309	Continued From page 13 report, in the nursing notes and monitored until healed.	F 309		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R40) reviewed for activities of daily living (ADLs), received assistance with shaving. Findings include: R40's diagnosis sheet, dated 8/3/17, identified a diagnosis of sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) due to cholangitis (an infection of the bile ducts.) R40's admission Minimum Data Set (MDS), dated 5/4/17, identified a Brief Interview for Mental Status (BIMS) score of 14 indicative of intact cognition. R40's MDS also indicated R40 needed extensive assistance with grooming. R40's Care Area Assessment (CAA) for ADL's dated 5/4/17, indicated R40 required one staff assistance with ADLS. See care plan for specific interventions. R40's care plan, revised 7/30/17, indicated R40 required assistance of one staff member with	F 311	It is the policy of the Sleepy Eye Care Center that a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. Resident #40 Chin was shaved on 8/7/2017. Nursing Staff will be educated on Sept 5th, 2017 on removing male and female facial hair with morning cares and to do nail care on residents on bath day and as needed. All Resident ADL Care Plans were reviewed and revised as needed. Policy and Procedure for Shaving was reviewed and revised as needed. Routine audits for removal of facial hair and nail care to be completed on all residents weekly x4 weeks. The results of the audits will be reported to the QAPI	9/12/17

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	245225	A. BUILDING _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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F 311	Continued From page 14 personal hygiene. During observation on 7/31/17, at 3:14 p.m. R40 was observed sitting in her recliner. R40 was observed to have numerous 1/4 inch long hair along chin/jaw line. During observation on 8/2/17, at 1:08 p.m. R40 was observed sitting in recliner. R94 continued to have 1/4 inch hair along her chin/jaw line. R94 rubbed the hair and stated well I can't see good enough to do it myself so they are supposed to do it. She stated I need that done but I can't do it myself. During interview on 8/2/17, at 1:28 p.m. nursing assistant (NA)-E verified the presence of R94's chin hair. She stated it should be shaved and if the resident does not have a razor the facility had disposable ones for their use. During interview with the director of nursing on 8/3/17, at 11:00 a.m. she stated residents should be shaved with cares as needed. A policy regarding grooming was requested but none was provided.	F 311	Committee and the recommendations of the Committee will be followed. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for 1	F 312	It is the policy of the Sleepy Eye Care Center to ensure that a resident who is	9/12/17

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F 312	Continued From page 15 of 3 residents (R19) reviewed for activities of daily living (ADLs) who was dependent on staff for personal care. Findings include: R19 had been observed on 8/1/17, at 9:43 a.m. seated in wheelchair (w/c) in room with long soiled fingernails. R19's quarterly Minimum Data Set (MDS) assessment dated 5/25/17, included a brief interview for mental status (BIMS) score of 9 indicating moderate cognitive impairment. The MDS also indicated R19 required extensive assistance from staff with bed mobility, transfer, toilet use, personal hygiene, and dressing. The care plan last reviewed 6/20/17, indicated R19 required physical assist of one staff with dressing and personal hygiene. Review of the point of care tasks by nursing assistants for R19 included: Nails cleaned and trimmed by nursing assistant. R19's electronic health care record indicated this task was last completed on 7/27/17. On 8/2/17, at 8:40 a.m. nursing assistant (NA)-C was observed providing morning cares for R19; R19's fingernails continued to be long with black debris underneath the nails. During the observation NA-C did not provide nail care for R19. On 8/3/17, at 9:29 a.m. R19 was observed lying in bed with a hospital gown on. R19's fingernails continued to be long and soiled. At 9:32 a.m. NA-A entered R19's room and confirmed she would be providing morning cares for the resident	F 312	unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #19 Nails were trimmed and cleaned on August 6th, 2017. Nursing Staff will be educated on doing nail care on residents on bath day and as needed. All Resident ADL Care Plans were reviewed and revised as needed. Policy and Procedure for Shaving was reviewed and revised as needed. Routine audits for nail care to be completed on all residents weekly x4 weeks. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017.	

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F 312	Continued From page 16 prior to taking to breakfast. At 9:45 a.m. NA-A was observed propelling R19 out of room in w/c; the resident was dressed for the day. R19's fingernails were observed and continued to be long and soiled. NA-A positioned R19 outside of room in hall 3 then was observed to enter another resident's room. At 9:49 a.m. the director of nursing (DON) and surveyor observed R19's fingernails while still seated in w/c in hall 3. DON confirmed R19's fingernails were soiled and needed to be trimmed. DON advised the resident that she would clean and trim the fingernails after breakfast. When interviewed on 8/3/17, at 1:04 p.m. the DON verified nail care should be performed weekly with the resident's bath and in between if soiled.	F 312		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure temperatures were maintained to ensure palatability for 3 of 10 residents (R30, R62 & R26) who routinely received room trays.	F 364	It is the policy of the Sleepy Eye Care Center that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance. The facility will provide food and drink that is palatable,	9/12/17

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F 364	Continued From page 17 Findings include: R30 had been observed and interviewed on 7/31/17, at 6:05 p.m. R30 received a room tray and stated her chicken tenders were luke warm, and that her room tray was usually luke warm or cold when it got to her room. R62 had been observed and interviewed on 7/31/17, at 6:09 p.m. R62 stated her room tray was "Cold as always." R26 had been observed and interviewed on 7/31/17, at 6:07 p.m. trays were being delivered on hall 3. R26 received her meal tray and stated the food was not warm enough, "But what can they do?" R26 stated she was all the way at the end of the hall and wasn't sure there was anything the facility could do to ensure her meals were warmer. During observation on 8/2/17, at 12:01 p.m. room trays were being dished up onto a rolling cart for distribution. The cart was metal in construction and not insulated. A test tray was requested at this time, consisting of beef roast, broccoli and mashed potatoes. Ten room trays along with the test tray were dished up, covered and placed onto the cart. The dietary manager (DM) sent the cart, including the test tray with nursing assistant (NA)-D to be delivered to the residents. At. 12:10 p.m., NA-D passed the last meal tray to R26. R26 indicated her food was cold. The test tray item temperatures were checked at this time with the DM. The temperature of the potatoes was 110 degrees, the beef was 85 degrees and the broccoli was 85 degrees. The food was cool to the palate when sampled and the DM confirmed the temperatures of the items were not held at a	F 364	attractive, and at a safe an appetizing temperature. An insulted cart was ordered on August 24, 2017 in order to keep foods at required temperatures. It had been the practice of the facility to dish all room trays up at the same time and place them on a rolling cart for distribution. Until new cart arrives, will only transport and deliver trays to one hall at a time. All nursing staff and dietary staff were educated on change in practice on 9/5/2017. Random audits will be done weekly to ensure food is at required temperatures. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. The Dietary Manager is responsible for overall compliance along with reporting audit reports to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017.	

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F 364	Continued From page 18 palatable temperature. The DM indicated she had emailed her food service vendor "just today" about insulated carts and would provide documentation. No documentation was subsequently provided. The facility policy entitled Food Temperatures, undated indicated foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to maintain temperatures at or below 41 degrees Fahrenheit (F) for cold foods and at or above 135 degrees F for hot foods.	F 364		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to administer medication according to their policy for 1 of 1 resident (R17). Findings include: R17's quarterly Minimum Data Set assessment	F 425	It is the policy of the Sleepy Eye Care Center to provide pharmaceutical services to meet the needs of each resident. LPN-A was suspended pending investigation.	9/12/17

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F 425	Continued From page 19 dated 6/6/17, indicated R17 had a Brief Interview of Mental Status of 14/15 which indicated cognition was intact. The electronic medical record (EMR) listed R17's diagnoses as including: Chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease(GERD), major depressive disorder, and generalized anxiety. During interview on 7/31/17, R17 indicated licensed practical nurse (LPN)-A didn't bring her Reglan (medication for gastro-esophageal reflux) on time. R17 stated, "She will come in at noon, should be at 11:00 a.m." R17 indicated this occurred on a recurrent basis. The physician order with a start date of 5/4/15 listed: Reglan tablet 10 milligram (mg) 1 tablet by mouth (PO) three times a day (TID) for gastroesophogeal reflux disease (GERD). Take three times daily before meals. Manufacturer's recommendation is 30 minutes before meals. R17 requested this medication one hour before her meals. Review of the July 2017, Medication Administration Record (MAR) indicated R17 received Reglan TID at 7:00 a.m.; 11:00 a.m. and 5:00 p.m. Scheduled meal times were listed as: Breakfast-6:30 a.m.- 10:30 a.m.; Lunch-10:30 a.m. - 12:00 noon (R17 indicated she ate at 12:00 noon); and Supper-6:00 p.m. During continuous observation on 8/1/17, at 10:58 a.m. R17 was interviewed and indicated she had not yet received her Reglan, nor had she received her nebulizer treatment ordered every four hours. R17 indicated she should have received the nebulizer treatment at 10:00 a.m. LPN-A was observed passing medications to residents on the 100 wing at this time. At 11:22	F 425	LPN-A and NA-A were educated immediately after the incident on the rights of a medication pass and that the standard of care is to have a nurse or TMA pass medications. LPN-A was reported to Board of Nursing and corrective action was given. Policy and Procedures for Medication Administration were reviewed and revised as needed. Facility policy for Standard of Practice in Medication Administration by a Licensed Nurse or TMA was reviewed and revised as needed. All Nursing Staff were educated on Medication Administration Policy and Procedure and Standard of Practice in Medication Administration. Medication Administration Audits will be conducted weekly for one month and periodically thereafter. The results of the audit will be reported to the QAPI Committee and the recommendations of the Committee will be followed, The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it is in substantial compliance at this time.	

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F 425	Continued From page 20	F 425		

a.m. LPN-A continued to pass medications on the 100 Wing. At 11:30 a.m. LPN-A went to the 300 wing indicating she needed to pass medications on that wing. R17's room was located on the 300 wing. At 11:41 a.m., LPN-A continued to pass medications to other residents, passing by R17's room repeatedly but not stopping or acknowledging R17. LPN-A proceeded to pass medications to residents in rooms located on either side of R17, but did not speak to or make any reference to R17's medication which was scheduled to be administered at 11:00 a.m. Observation continued with LPN-A returning to the computer screen on top of the mediation cart at 11:46 a.m. and scrolling through the medications to be given. The screen changed color from green to pink when a medication was due. The screen for R17's medication was pink in color indicating she had medication scheduled to be passed. At 11:48 a.m. writer stepped away from the medication cart and LPN-A to speak with a team member and when turned back and checked on R17 at 11:51 a.m. she was noted to be self administrating a nebulizer treatment. When asked who had set this up for her, R17 indicated the nursing assistant (NA)-A had set it up and indicated she always brought her medications when LPN-A was working.

During interview on 8/1/17, at 11:59 a.m. LPN-A confirmed the noon meal was served at 12:00 p.m. and it was the responsibility of the nurse assigned to Wing 300 to pass all the medications for the 300 wing in addition to administering medications to residents on one side of the hall on the 100 wing. When LPN-A was asked about R17's medications, LPN-A replied R17 didn't like her so the trained medication aid (TMA) administered her medication and nebulizer

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F 425	Continued From page 21	F 425		

treatments.

During interview on 8/1/17, at 12:12 p.m. NA-A indicated she had administered R17's nebulizer treatment and also her Reglan. NA-A indicated she did this because R17 didn't like LPN-A and did not want her to come into her room . NA-A further indicated she had not kept up her TMA certification and had been working as a NA since the change to the computerized system for medication administration. During a subsequent interview on 8/1/17, at 12:30 p.m. NA-A was asked when she had obtained the medications for R17 and replied the medications had been handed to her by LPN-A while this writer was speaking with a team member and had her back to LPN-A at 11:48 a.m. When asked about documentation onto the MAR of the medication administered, NA-A indicated LPN-A did that and she just took the medication to R17. NA-A further indicated LPN-A continued to pass other medications and did not actually watch NA-A administer the medication to R17.

During a subsequent interview on 8/1/17, at 12:35 p.m. R17 stated, "Got Reglan at ten to noon, today" and confirmed she had received her nebulizer treatment at the same time she received her Reglan. R17 then indicated this was not an infrequent occurrence. R17 further indicated the aide came and gave her all of her morning meds as well as her 7:00 a.m. and 11:00 a.m. Reglan tablet. When questioned if receiving the Reglan less than an hour before her meal bothered her, R17 indicated she had burning in the back of her throat when she did not get her Reglan soon enough before she ate her meals.

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F 425	Continued From page 22 During interview on 8/1/17, at 12:36 p.m. the director of nursing (DON) indicated her expectation was for an approved trained medication aide (TMA) or licensed nurse to pass medications and a NA would not be allowed to pass medications. The DON indicated she was not aware this was occurring and would investigate the situation immediately. During a subsequent interview on 8/3/17, at 9:45 a.m. NA-A indicated she had been assisting with administration of R17's medications for at least a year or since the computerized MAR system was put into place. NA-A indicated that was also when she stopped working as a TMA and continued working as a NA. NA-A verified she had administered all of R17's medications including doctor ordered controlled medications that had been set up and were documented by LPN-A. There was not a policy provided that addressed medications being administered in the above documented situation. The Volunteers of America policy Oral Medication Administration Procedures listed: Check medication label against the resident's medical record one last time and return medication to medication cart or storage area.; After medication is administered, initial medical record in space provided or follow your community's policy, "Pour-Pass-Document."; and Document any refusal or other reason medication was not administered as ordered.	F 425		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 431		9/12/17

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F 431	Continued From page 23 §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		

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F 431	Continued From page 24 (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly store prescription Triamcinolone cream from unauthorized access for 1 of 1 resident (R94) who had the prescription cream stored in their room. Findings include: R94's 14 day PPS Minimum Data Set (MDS) assessment dated 7/4/17, identified R94 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS also identified diagnosis of local infection of the skin and subcutaneous tissue. R94's physician orders dated 8/3/17, identified R94 received Triamcinolone Acetonide cream 0.1% (a corticosteroid used to reduce swelling, redness, itching, and allergic reactions) twice daily on Sunday, Monday, Tuesday, Thursday and Friday. The cream was to be applied to active areas on arms, legs and trunk. A keep at bedside/self administer order for the Triamcinolone cream was not found. During observation on 8/2/17, at 7:25 a.m. R94 was observed to have a tube of Triamcinolone	F 431	It is the policy of the Sleepy Eye Care Center to provide pharmaceutical services to meet the needs of each resident. Resident #94 Triamcinolone cream was removed from resident□s drawer on 8/3/2017. Policy and Procedure for Medication Storage was reviewed and revised. All Nursing staff were educated on Medication Storage. An audit of all resident rooms was conducted to ensure that medications at bedside have order to be at bedside. Routine audits of residents□ rooms to ensure that medications at bedside have order to be at bedside will be done weekly x4 weeks. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. The Director of Nursing is responsible for overall compliance along with	

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	245225	A. BUILDING _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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F 431	Continued From page 25 cream in a drawer of her bedside stand. She stated, "I don't know anything about that stuff. They are supposed to be putting it on me but I always have to ask for it." During interview on 8/3/17, at 11:00 a.m. the director of nursing (DON) stated the Triamcinolone cream should not be in the drawer. She stated it should be applied by the nurse and kept in the medication cart. The DON removed the cream from the drawer. A policy regarding medication storage was requested but none was provided.	F 431	communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, 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 (facility assessment implementation is Phase 2); (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	F 441		9/12/17

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F 441	Continued From page 26	F 441		

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.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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F 441	Continued From page 27 (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 appropriate hand hygiene was followed to prevent the spread of infection for 1 of 3 residents (R19) observed for activities of daily living (ADLs). Findings include: R19's quarterly Minimum Data Set (MDS) assessment dated 5/25/17, included a brief interview for mental status (BIMS) score of 9 indicating moderate cognitive impairment. The MDS also indicated R19 required extensive assistance from staff with bed mobility, transfer, toilet use, personal hygiene, and dressing, and was frequently incontinent of urine. The care plan last revised 6/20/17, indicated R19 required physical assist of one staff with dressing and personal hygiene. During observation on 8/2/17, at 8:40 a.m. nursing assistant (NA)-C was assisting R19 with routine morning cares. R19 was lying on back in bed with a clean open incontinence product underneath his bottom. With gloved hands NA-C provided perineal cares using a wet washcloth then drying with a clean towel. NA-C then attached the incontinence brief around the resident and attempted to sit R19 up on the edge of the bed still wearing the same gloves. R19 was unable to sit up without support; NA-C indicated the resident had recently been hospitalized and was still very weak. NA-C stated he would need assistance from another staff to	F 441	It is the policy of the Sleepy eye Care Center to have an infection prevention and control program that includes hand hygiene procedures to be followed by staff involved in direct resident contact. Policy and Procedure for Standard Precautions was reviewed and revised as needed. Policy and Procedure for Glove Usage and Technique was reviewed and revised as needed. All Nursing Staff were educated on Standard Precautions and Glove Usage and Technique. Routine infection control hand hygiene audits will be done weekly x4 weeks. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017.	

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F 441	Continued From page 28	F 441		

safely transfer R19 using the standing lift. NA-C assisted R19 with lying back down in bed, then using the same gloved hands opened the door to R19's room and asked licensed practical nurse (LPN)-C to request assistance from NA-A. Shortly afterwards NA-A entered R19's room and assisted NA-C with sitting the resident up in bed, getting dressing and getting the sling around the resident and hooked up to the standing lift. NA-C continued to wear the same gloves he had used when providing perineal care to R19. NA-C touched R19's clothing, the lift sling, and ran the controls and touched the handles on the lift. NA-C then pushed the resident into the bathroom on the lift still wearing the same gloves. Once R19 was in the bathroom and seated on the toilet, NA-C then removed the gloves, washed his hands, and donned clean gloves. NA-A exited the room at that time. NA-C then obtained R19's oral care supplies and asked the resident if he wanted to brush his teeth, R19 refused. When R19 was finished in the bathroom, NA-C (wearing the gloves donned after washing hands) brought the resident partway out of the bathroom then provided perineal care for the resident. NA-C then obtained an incontinence product from the bag on the lift and started to apply to resident; NA-A entered R19's room at that time to assist. NA-A assisted NA-C with pulling up R19's pants. NA-C then ran the controls of the standing lift and with NA-A assisted R19 into his wheelchair. NA-C then continued to bag up the resident's dirty clothing and linens into a bag. NA-A asked NA-C to clean R19's eye glasses. NA-C, wearing the same gloves he had worn to provide perineal care to the resident, obtained the glasses from NA-A, washed and dried R19's glasses, then gave back to NA-A to put on the resident. NA-A assisted R19 with putting on the eye glasses then

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F 441	Continued From page 29 exited the room. NA-C then proceeded to comb the resident's hair and put R19's hygiene supplies away in drawers while still wearing the same gloves used to provide perineal care to the resident. When NA-C had completed cleaning up R19's room he then removed the gloves, washed hands and stated he would be taking R19 to breakfast. When interviewed on 8/2/17, at 9:02 a.m. NA-C stated being trained to change gloves after providing perineal care for a resident. NA-C stated not realizing he had not changed gloves timely after providing perineal care for R19 and confirmed that he should have. When interviewed on 8/2/17, at 9:50 a.m. the director of nursing (DON) and infection control registered nurse (RN)-A stated expectations would be to remove gloves and cleanse hands following perineal care. RN-A further added staff were not to leave a resident's room wearing gloves. The policy title, Glove Technique (Non-Sterile) dated 2017, included: Don clean gloves between tasks and procedures on the same resident after contact with blood, body fluids, secretions, excretions. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. Wash and or sanitize hands after the removal of gloves.	F 441		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions	F 465		9/12/17

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F 465	Continued From page 30 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to ensure resident bathrooms were maintained in a clean and a state of good repair for 7 of 7 rooms Room 1, 2, 5, 6, 7, 8, 9, 10, & 13) located on the secured unit. Findings include: During the tour on 8/3/17, at 2:00 p.m. with the maintenance supervisor (MS) the following observations were noted: Room 1 which had a shared bathroom had black dust/dirt areas noted along the edge of floor where the linoleum and molding met and in all four corners of the room extending 1/2 inch from the corner. The door frames had multiple scratches with paint missing exposing the bare surface and rust colored discoloration extending 4 inches up the door frame. Room 2 with a private bathroom had the bathroom door frame with multiple paint chips and rust colored discoloration. The bathroom floor had black dust/dirt in the corners and along the edge of the floor and molding. There was an irregular shaped area about 6 inches in diameter of brown discoloration noted on the linoleum	F 465	It is the policy of the Sleepy Eye Care Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Room 1 " The room and shared bathroom were thoroughly cleaned. " The door frames were cleaned and painted. Room 2 " The bathroom door frame was cleaned to remove the rust color discoloration and painted where necessary. " The brown discoloration noted on the linoleum under the left side of the bathroom sink has been cleaned but some discoloration still exists. Flooring and molding are scheduled to be replaced by September 12, 2017 Room 5 " Shared bathroom was cleaned. " Flooring and molding is scheduled to be replaced by September 12, 2017 Room 6 & 7 " Shared bathroom door was stained and varnished along the lower six inches	

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F 465	Continued From page 31 under the left side of the bathroom sink. Room 5 with a shared bathroom had a strong urine odor and a soiled brief was noted in trash. All four corners of bathroom had black colored dust/dirt in the corners extending out 1/2 inch from the wall molding and the linoleum edges were curled on the Room 5 side of the room. Room 6 & 7 with shared bathroom had the bathroom door with varnish scraped exposing the bare wood along the lower six inches of the door edge. Room 8 bathroom had black dust/dirt along the edge of the linoleum and molding and buildup in all four corners. Room 9 & 10 with shared bathroom had 4 and 1/2 inch scrapes with paint missing on the door frame entering from room 9. The inside door frame across from the sink had one inch areas of chipped paint, the adjoining room door frame had multiple scraped areas and the door frames had areas of multiple rust colorations extending to 6 inches above the floor. There was build up of black dust/dirt in all four corners of the bathroom and along the molding where the linoleum and wall joined. Room 13 with a private bathroom had black dust/dirt along the molding and in all four corners in addition to the seam in the linoleum along the right side of the sink was curling away from the molding. During interview with the MS on 8/3/17, at 2:15 p.m. it was verified there was not a routine inspection or repair schedule in place for the 100	F 465	of the door edge. Room 8 " Bathroom was cleaned. Room 9 & 10 " Bathroom door frames were cleaned to remove rust colorations and painted where paint was chipped. " Bathroom was cleaned. Room 13 " Bathroom was cleaned. " Flooring and molding are scheduled to be replaced by September 12, 2017 On August 22, 2017 the housekeeping staff was educated by the maintenance supervisor on housekeeping protocols, checklists and schedules for cleaning. A schedule for replacing facility bathroom floors and moldings is as follows: " Rooms 13, 15, 42, & common area BRs Completed " Rooms 2, 5 and 13 September 12, 2017 " Rooms 1, 6, and 7 September 30, 2017 " Rooms 8, 9, 10 and 14 November 15, 2017" Rooms 16, 17, 18 and 19 November 30, 2017 " Rooms 20, 21, 22 and 23 December 1, 2017 " Rooms 24, 25, 26 and 27 December 15, 2017 " Rooms 28, 29,30 and 31 December 30, 2017 " Rooms 32, 33, 34, and 35 January 1, 2018 " Rooms 36, 37, 38, and 39 January 15, 2018	

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F 465	Continued From page 32 wing. It was further verified that the bathroom floors in the observed rooms were not cleaned in a through manner, and the identified areas needed to be repaired. The MS further indicated he was working on repairs for facility bathrooms, but there was no schedule or date of implementation available.	F 465	" Rooms 40, 41 and 42 January 30, 2018 An audit will be performed on 10% of resident rooms on a weekly basis for four weeks. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. The administrator is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance by September 12, 2017 and complete all action items by January 30, 2018 F000 Submission of this credible allegation of compliance by Sleepy Eye Care Center is not a legal admission that a deficiency exists or that the statement of deficiencies were cited correctly. It is not to be construed as an admission against interest of the facility, its administrator, employees, agents or other individuals who draft or may be documented in this credible allegation of compliance. The preparation and submission of this document does not constitute an admission of agreement with the alleged deficiencies or conclusions made by the survey agency. This credible allegation of compliance is submitted due to state and federal law requirements as a condition to	

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F 465	Continued From page 33	F 465	participate in the Medicare and Medicaid programs.	

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Sleepy Eye Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2017

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Sleepy Eye Care Center is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(000) construction. In 1985, addition was constructed and was determined to be of Type II(000) construction.

Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification.

The facility has a capacity of 61 beds and had a census of 55 at time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to be in accordance with Chapter 7, which states, all means of egress is to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect 55 of the 55 residents. Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 08/02/2017, observation revealed several wheelchairs, folding chairs and patient lifts stored within the path of egress in Hall #2. This deficient practice was verified by the Facility	K 211	F000 Submission of this credible allegation of compliance by Sleepy Eye Care Center is not a legal admission that a deficiency exists or that the statement of deficiencies were cited correctly. It is not to be construed as an admission against interest of the facility, its administrator, employees, agents or other individuals who draft or may be documented in this credible allegation of compliance. The preparation and submission of this document does not constitute an admission of agreement with the alleged deficiencies or conclusions made by the survey agency. This credible allegation of compliance is submitted due to state and federal law requirements as a condition to participate in the Medicare and Medicaid programs. K211 □ NFPA 101 Means of Egress □ General	9/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**08/02/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	**1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085**

(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
K 211	Continued From page 3 Maintenance Director.	K 211	It is the policy of the Sleepy Eye Care Center to maintain all aisles, passageways, corridors, exit discharges, exit locations and accesses in accordance with Chapter 7 and to continually maintain the means of egress of all obstructions to full use in case of emergency. Hall #2 " The Policy and Procedure for maintaining the means of egress of all obstructions was reviewed and revised as needed. " Hall #2 was cleared of all obstructions. " Nursing staff were educated on keeping all means of egress continually free of obstruction. " Random weekly audits will be performed for four weeks to ensure that all means of egress are free from obstruction. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. " The facility administrator is responsible for overall compliance along with communicating results of the audits to the QAPI meeting. " The facility alleges that it will be in substantial compliance and complete all action items by Sept 12, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 346 SS=D	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. This deficient practice could effect 55 of the 55 residents. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 08/02/2017, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current Staff/Fire Marshal contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346	K346 - NFPA 101 Fire Alarm System – Out of Service It is the policy of the Sleepy Eye Care Center to provide a current and accurate Fire Alarm System Out of Service Policy. • The Fire Alarm System Out of Service Policy was revised by the facility administrator to reflect current Staff and Fire Marshall contact information. The policy was reviewed and approved by the Sleepy Eye Care Center Safety Committee and individual disaster plan binders were updated on August 23, 2017. • The supervisor of maintenance will audit the policy on a monthly basis and make updates as required. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. • The administrator is responsible for overall compliance along with communicating results of audits to the QAPI Committee.	8/25/17

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	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**08/02/2017**

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K 346	Continued From page 5	K 346	• The facility alleges to be in substantial compliance at this time.	
K 354 SS=D	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. This deficient practice could effect 55 of the 55 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or	K 354	K354 – NFPA 101 Fire Sprinkler System – Out of Service It is the policy of the Sleepy Eye Care Center to provide a current and accurate Fire sprinkler System Out of Service Policy. • The Fire Sprinkler System Out of Service Policy was revised by the facility administrator to reflect current Staff and Fire Marshall contact information. The policy was reviewed and approved by the Sleepy Eye Care Center Safety Committee and individual disaster plan binders were updated on August 23, 2017. • The supervisor of maintenance will	8/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**08/02/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	**1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085**

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K 354	Continued From page 6 an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 9:00 AM and 1:00 PM on 08/03/2017, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current Staff/ Fire Marshal contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 10:00 AM and 2:00 PM on 08/02/2017, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current Staff/ Fire Marshal contact information and the 10 hour	K 354	audit the policy on a monthly basis and make updates as required. The results of the audits will be reported to the QAPI Committee and the recommendations of the Committee will be followed. • The administrator is responsible for overall compliance along with communicating results of audits to the QAPI Committee. • The facility alleges to be in substantial compliance at this time.	

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	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**08/02/2017**

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K 354	Continued From page 7 out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354		