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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 341P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00016

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245597**

2.STATE VENDOR OR MEDICAID NO.
(L2) **863840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE CARE CENTER**
(L4) **16561 US HIGHWAY 10**
(L5) **LAKE PARK, MN** (L6) **56554**

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 **08/29/2017** (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)
09/30

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

12.Total Facility Beds **34** (L18)
13.Total Certified Beds **34** (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
	34			
(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 :
Tammy Williams, HFE - NE II 09/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 09/05/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
02/01/1992
(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.
00660
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/22/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245597 September 5, 2017

Ms. Danielle Olson, Administrator
Sunnyside Care Center
16561 US Highway 10
Lake Park, MN 56554-9302

Dear Ms. Olson:

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 July 28, 2017 the above facility is recommended for:

34 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 34 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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 5, 2017

Ms. Danielle Olson, Administrator
Sunnyside Care Center
16561 US Highway 10
Lake Park, MN 56554-9302

RE: Project Number S5597026

Dear Ms. Olson:

On July 31, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 13, 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 29, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 24, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 28, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 13, 2017, effective July 28, 2017 and therefore remedies outlined in our letter to you dated July 31, 2017, will not be imposed.

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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 341P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L1) **245597**

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(L2) **863840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE CARE CENTER**
(L4) **16561 US HIGHWAY 10**
(L5) **LAKE PARK, MN** (L6) **56554**

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 **07/13/2017** (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)
09/30

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

12.Total Facility Beds **34** (L18)
13.Total Certified Beds **34** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
	34			
(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 :
Beth Nowling, HFE - NE II 08/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 08/22/2017 (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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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1992
(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.
00660
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 31, 2017

Ms. Danielle Olson, Administrator
Sunnyside Care Center
16561 U.S. Highway 10
Lake Park, MN 56554-9302

RE: Project Number S5597026

Dear Ms. Olson:

On July 13, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. An electronic copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 August 22, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 22, 2017 the following remedy will be imposed:

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

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.

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 October 13, 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 January 13, 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 electronic 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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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
	245597	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

(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 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 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		7/31/17

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

Electronically Signed | 08/15/2017

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
	245597	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

(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 156	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

(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 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

(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 156	Continued From page 3 (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 156		

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regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current Combined Federal and State Bill of Rights for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities	F 156	CORRECTIVE ACTION: On July 17th, 2017 a large print listing of all contact information was placed near the Residents Rights poster. A sticker with the correct contact information was placed	

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F 156	Continued From page 6 dated 11/28/16, was displayed for the facility residents to view. This had the potential to affect all 28 residents currently residing in the facility. Findings include: On 7/10/17, at 2:32 p.m. the Bill of Rights (BOR) was observed posted in the main hallway leading to the nurse's station which was not the most current version which was revised 11/28/16. Postings for BOR and Medicare and Medicaid were hung separately on the wall in approximately 18 by 36 inch wood frames. The BOR posting lacked revised information including email addresses for pertinent state agencies and advocacy groups. The outdated BOR sat in the wooden frame in a manner that made the telephone numbers for the state agencies and advocacy groups difficult to read. The Medicare and Medicaid posting also showed outdated information stating the Medicare intermediary was Noridian, instead of the correct KePRO. On 7/13/2017 at 1:45 p.m. the director of nursing (DON) stated she was not aware the BOR did not have the email addresses, and was not aware the phone numbers were not readable. She stated they had given the residents the new bill of rights booklets. A policy for the Bill of Rights was requested, but not provided.	F 156	over the incorrect contact number on the Medicare poster. The new posters are on order from Leading Age of Minnesota. CORRECTION ACTION AS IT APPLIES TO OTHER RESIDENTS: The information is available for all residents, families and visitors at all times. DATE OF COMPLETION: July 31, 2017 Reoccurrence will be prevented by: DON or designee will audit the contact information weekly x4, then monthly for compliance. DON will report audit findings to the QA committee on a quarterly basis for further direction for ongoing compliance.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered	F 280		7/28/17

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F 280	Continued From page 7 plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans	F 280		

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F 280	Continued From page 8 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include specific behavioral interventions identified	F 280	CORRECTIVE ACTION: The care plan for resident R30 was revised on July 14th, 2017. All staff was made aware via the	

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F 280	Continued From page 9 for 1 of 1 resident (R30) reviewed for dementia care services. Findings include: R30's Admission Minimum Data Set (MDS) dated 5/13/17, indicated R30 had severe cognitive impairment and diagnoses which included dementia, anxiety, depression and Schizoaffective disorder. The MDS identified R30 required total assistance from staff for activities of daily living (ADL's,) and had difficulty making herself understood. The MDS indicated R30 had exhibited behavioral symptoms of threatening or screaming at others and had rejected and hit out towards staff with cares one to three days during the assessment period. The MDS further identified R30 had received daily antipsychotic, antidepressant and antianxiety medications. R30's care plan revised 5/25/17, revealed R30 had problems with communication, impaired cognition and thought processes and directed facility staff to anticipate and meet her needs, use R30's preferred name when speaking to her, identify yourself at each interaction, allow R30 time to respond, do not rush when speaking to her, face when speaking and make eye contact and turn off the TV/radio to reduce noise. R30 understands consistent simple, directive sentences, ask yes/no questions, use simple, brief, consistent words/cues and alternative communications tools as needed. The care plan indicated R30 would yell out, hit at staff when providing cares and directed staff to provide explanation of all care activities prior to and as they occur during each contact allowing her time to adjust to changes, praise R30 when behavioral appropriate. The care plan indicated R30 liked	F 280	facility TQM (total quality management) communication tool which is distributed to all departments weekly and read daily at nursing shift reports. Resident R30 task list was updated to include resident specific interventions for behaviors. CORRECTIVE ACTION AS IT APPLIES TO OTHER RESIDENTS: each department supervisor spoke 1:1 with their staff to assure staff member knowledge in the care of residents with dementia and the use of the Kardex to further guide them in resident specific behaviors. The facility will be mindful in upcoming training of the ongoing need to focus on dementia care. DATE OF COMPLETION: July 28th, 2017 Reoccurrence will be prevented by: DON or designee will audit the care plans of residents with behaviors weekly x 4 then monthly for compliance. DON will report audit findings to the QA committee on a quarterly basis for further direction.	

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music and had attended church in the past, however R30 could be disruptive due to dementia and would yell out/sing loudly. Staff were directed to provide 1:1 visits if R30 was unable to attend group activities and her preferred activities were identified as listening to music in her room and being with family. The care plan further revealed R30 received antipsychotic, antidepressant and antianxiety medications.

R30's Sunnyside Care Center Kardex Report form dated 7/12/17, revealed the aforementioned care plan information and interventions. However, the Kardex also indicated staff were to provide R30 the necessary cues when speaking with her and to stop and return later if R30 was agitated which was not identified on R30's care plan.

R30's Follow Up Question Report form dated 7/12/17, revealed interventions provided to R30 included change of resident position, entertainment, healing touch such as lotion/massage, quiet/comfortable setting, and conversation/reminiscing. However, these identified interventions were not included on R30's care plan.

During an observation on 7/10/17, at 4:24 p.m. R30 was seated in a wheelchair in her room. R30 was hollering out non-sensible words repeatedly.

On 7/11/17, at 2:25 p.m. R30 was observed lying in bed on her back, in her room and would yell loudly non-sensible words, mixed with a repetitive phrase, "all the way."

On 7/12/17, at 8:14 a.m. R30 was observed seated in her wheelchair in her room, at that time the director of nursing (DON) wheeled R30 to the

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dining room and entered a closed area of the dining room named, Rosemary's garden, and wheeled R30 up the the long table and shut the door behind her. DON then proceeded to sit next to R30 and converse with her.

-At 8:17 a.m. R30's breakfast was brought into the room and DON proceeded to feed R30 her entire breakfast. During R30's breakfast she would periodically holler out non-sensible phrases with brief periods of silence.

-At 8:38 a.m. DON assisted R30, who remained seated in her wheelchair, out of the dining room and had asked NA-H to assist R30 to her room. NA-H stopped and picked up a cookie and cup of water at the kitchen window, then wheeled R30 to her room. At that time NA-H and NA-D assisted R30 to bed. NA-H turned R30's radio with a compact disc (CD) player and played an Elvis Presley CD for R30.

On 7/13/17, at 1:47 a.m. the DON stated she felt coming up with interventions for R30's verbal behaviors was a work in progress. DON confirmed R30's current care plan did not include identified specific, individualized interventions. DON stated the facility's usual practice for updating care plans was to attempt numerous interventions, verbally discuss them with the staff during shift to shift report and would then update R30's care plan with quarterly updates.

On 7/13/17, at 2:53 p.m. the activity director (AD) stated she had completed R30's psychosocial assessment upon admission and had used R30's family member and R30 has sources of information. AD stated she had been attempting numerous interventions for R30's loud, repetitive

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F 280	Continued From page 12 verbalization. The AD stated she felt R30 responded well to music and 1:1 visits and felt R30's mood and behavior fluctuated throughout the course of the day and at times she was calm and other times an intervention that had worked the week before, like reading, had not worked the next week. AD confirmed various interventions were not listed on R30's care plan. Review of a facility policy titled, Dementia, revised March, 2015, directed facility staff to identify a resident centered care plan to maximize remaining function and quality of life. The interdisciplinary team would adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions or complaints, changes in resident or family wishes, etc.	F 280		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.	F 428		7/28/17

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F 428	Continued From page 13 (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified the need for identified parameters for use of dual analgesics for 2 of 5 residents (R25, R23) reviewed for unnecessary medications.	F 428	CORRECTIVE ACTION: Residents R23 and R25 had pain medication orders revised with MD input on 7/25/17. CORRECTION ACTION AS IT APPLIES	

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F 428	Continued From page 14 Findings include: R25's Annual Minimum Data Set (MDS) dated 5/27/17, revealed R25 had moderate cognitive impairment and diagnoses which included arthritis, depression, anxiety and chronic obstructive pulmonary disease (COPD). The MDS also indicated R25 required extensive assistance from facility staff with activities of daily living (ADL's,) and had received as needed (prn) pain medications. The MDS revealed R25 had denied pain during the assessment period. R25's Cognition Care Area Assessment dated 5/27/17, revealed R25 had moderate cognitive impairment and his overall condition was declining. R25's care plan revised 5/25/17, indicated R25 was on comfort cares and directed staff to ensure his comfort. R25's care plan revealed R25 had an alteration in musculoskeletal status and directed facility staff to anticipate and meet his needs. Review of R25's physician orders signed 5/23/17, revealed orders for Morphine Sulfate solution 100 milligrams (mg)/ 5 milliliters (ml), give 2.5 mg by mouth (po) every one hour as needed (prn) for pain, comfort cares, give 0.125 ml. An order for Tylenol 325 mg, give 2 tablets by mouth every 6 hours prn for moderate pain, not to exceed 3000 mg in 24 hours, also on scheduled Tylenol three times a day (tid.) R25's physician orders lacked guidance for what level of pain was indicated to use the morphine and when to use the Tylenol for pain.	F 428	TO OTHER RESIDENTS: All medication orders were reviewed by DON. No further issues were noted. Each licensed nurse was educated on the importance of clear parameters and directions for the use of pain medication. DATE OF COMPLETION: July 28th, 2017 Reoccurrence will be prevented by: DON or designee will audit new pain medication orders monthly x3 for compliance. The Consultant Pharmacist has been monitoring monthly. DON will report audit findings to the QA committee on a quarterly basis for further direction.	

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Review of R25's medication administration records (MAR) from May 2017, to July 2017, revealed the following:

-May 2017, R25 had received Morphine 25 times for pain levels that ranged from a 3 to 6 on a numeric pain scale (0 being no pain and 10 being the worst pain imaginable.) The MAR further revealed R25 had received Tylenol 650 mg 5 times for pain levels ranging form a 4 to 6. The MAR revealed all but one dose of morphine, analgesic administrations were effective in relieving R25's pain.

-June 2017, R25 had received morphine 10 times for pain levels that ranged from 1 to 6, and R25 had received Tylenol 10 times for pain levels ranging from 4-6. The MAR revealed all administrations provided effective pain relief.

-July 2017, MAR revealed R25 had not received morphine and had received Tylenol 9 times for pain levels that ranged from a 1 to 7. The MAR revealed all administrations provided effective pain relief.

Review of the consultant pharmacy review for R25 from 4/25/17, to 6/29/17, revealed no recommendation for parameters of indication of use for R25's morphine and Tylenol orders.

On 7/13/17, at 10:33 a.m. licensed practical nurse (LPN)-A confirmed R25 had physician orders for both morphine and Tylenol. LPN-A confirmed R25's physician orders lacked indications on when to use which medication for pain and to what level of pain each medication should be used for. LPN-a stated her usual practice was to ask R25 which medication he wanted and she

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SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

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would then honor his request. LPN-A further stated she felt R25 had received relief from his headaches and leg aches when he used the morphine.

On 7/13/17, at 1:33 p.m. during a phone interview with the pharmacist consultant (PC), he stated residents that had multiple medications for pain should have indications or parameters on when to use which medication. The pharmacist further stated he had been working with the facility during the last quarter on ensuring parameters were in place for prn medications including morphine and Tylenol use for pain. Pharmacist confirmed he had not identified R25's physician orders for morphine and Tylenol did not have parameters or indications on which medication to use.

On 7/13/17, at 1:45 p.m. the director of nursing (DON) stated she would expect parameters to be listed for R25's morphine and Tylenol orders. She also stated she would expect the resident to have a choice on what he wanted to receive.

R23's admission MDS dated 6/7/17, identified R23 had diagnoses which included arthritis, COPD and restless leg syndrome. The MDS identified R23 had severe cognitive impairment, and was totally dependent on staff assistance for bed mobility, transfers, toileting, dressing and personal hygiene. Further, The MDS identified R23 had pain or possible pain observed daily and received as needed medications for pain.

R23's Care Area Assessment dated 6/13/17, idenfied R23 had impaired cognition and pain related to restless leg syndrome, and received as needed pain medication.

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R23's care plan, revised 6/14/17, listed R23 had acute/chronic pain related to hip fracture and restless leg syndrome and received pain medication of morphine and Tylenol related to hip fracture. R23's care plan listed various interventions which included to administer analgesic medications as ordered by physician and monitor and document effectiveness every shift.

R23 received Morphine Sulfate for pain 36 times in June, 2017. The physician orders included Morphine Sulfate 2 mg by mouth every 1 hour as needed for moderate to severe pain. The orders lacked guidance to determine what indicated moderate to severe pain.

R23 received Tylenol as needed for pain 1 time in June, 2017. The physician orders included Tylenol 325 mg tablet by mouth every 12 hours as needed for moderate pain. R23 received Tylenol 1 time in June. The orders lacked guidance to determine what indicated moderate pain.

Review of the Pharmacy Note completed 6/29/17, at 11:25 a.m. indicated there were no recommendations at that time. The documentation further identified the Morphine Sulfate was reviewed by the pharmacist. The documentation indicated a Morphine Sulfate allergy, use was clarified on admission, and R23 appeared to tolerate the Morphine use. The pharmacy note lacked recommendation for perimeters or guidance for staff to determine what indicated moderate to severe pain and when it would be appropriate to give Morphine Sulfate verses Tylenol.

Review of R23's MARs from 6/1/17, to 7/12/17,

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F 428	Continued From page 18 revealed the following: -6/1/17, R23 received Morphine Sulfate 2 times. R23's pain level was documented at 7 and 5. -6/2/17, R23 received Morphine Sulfate 8 times. R23's pain level was documented at 2, 4, 8, 8, 5, 7, 1 and 4. -6/3/17, R23 received Morphine Sulfate 8 times. R23's pain level was documented at 6, 4, 4, 5, 5, 4, 5 and 5. -6/4/17, R23 received Morphine Sulfate 8 times. R23's pain level was documented at 3, 4, 4, 5, 5, 5, 6 and 5. -6/6/17, R23 received Morphine Sulfate 3 times. R23's pain level was documented at 5, 3 and 5. -6/7/17, R23 received Morphine Sulfate 3 times. R23's pain level was documented at 3, 5 and 3. -6/8/17, R23 received Morphine Sulfate 2 times. R23's pain level was documented at 5 and 1. -6/9/17, R23 received Morphine Sulfate 2 times. R23's pain level was documented at 4 and 6. -6/11/17, R23 received Morphine Sulfate 1 time. R23's pain level was documented at 4. -6/13/17, R23 received Morphine Sulfate 1 time. R23's pain level was documented at 4. -6/14/17, R23 received Morphine Sulfate 1 time. R23's pain level was documented at 3. -6/15/17, R23 received Morphine Sulfate 1 time.	F 428		

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F 428	Continued From page 19 R23's pain level was documented at 5. -6/29/17, R23 received Tylenol 1 time. R23's pain level was documented at 5. On 7/13/17, at 1:33 p.m. the PC confirmed he had reviewed all of the facility's residents medication regimen monthly. PC further indicated he would expect there to be parameters for when to use which medication when multiple analgesic medications were ordered. PC confirmed he had not addressed this for R23 and had not made recommendations to the DON or attending physician to assure perimeters and guidance were in place for R23's Morphine Sulfate and Tylenol use. PC indicated he had worked with the facility in the past for education on perimeters for analgesic medications and he would address this again his next visit. On 7/13/17, at 1:45 p.m. the DON confirmed her expectation was for perimeters to be in place for residents on dual analgesic medication orders, including Morphine and Tylenol. On 7/13/17, at 3:28 p.m. the DON indicated she would expect the consultant pharmacist would identify the need for perimeters and make the appropriate recommendations. A facility policy titled, Medication Regimen Review Policy, dated 11/2016, revealed the CP reviewed all residents medical records monthly in order to identify irregularities	F 428		

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K 000	INITIAL COMMENTS FIRE SAFETY BUILDING 01 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 Sunnyside 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, and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/15/2017

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 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us and 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. Main Building 1975 1-story no basement Type II (000) In 2004 an entrance/ dayroom was added. 1-story no basement Type V (111) Since this addition was not separated by a 2 hour fire barrier, the entire facility is considered V (111) and surveyed as one building. The facility is divided by three smoke barriers creating 4 smoke compartments. The facility is fully sprinkler protected and has a manual fire alarm system with corridor smoke detection and sleeping room smoke detection which is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification The facility has a capacity of 34 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of three smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 5 of the 34 residents and an undetermined amount of staff and visitors. Findings include: At 10:15 am on 07/11/2017 observations revealed non-rated firestop at the top of the smoke barrier	K 372	CORRECTIVE ACTION: Environmental Director (Gary Ziebell) added 3M Fire Barrier fire rated caulking to the top of the smoke barrier wall on the south wing on 7/27/17. Responsible Party: Maintenance Supervisor	7/27/17

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K 372	Continued From page 3 wall in the south wing. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 372		