DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3NYD
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 **10/13/2014** (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 **42** (L18)

13.Total Certified Beds **42** (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 ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(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 :
Gail Anderson, Unit Supervisor 10/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Enforcement Specialist 10/21/2014 (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
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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245597
October 21, 2014

Ms.. Danielle Olson, Administrator
Sunnyside Care Center
16561 US Highway 10
Lake Park, Minnesota 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 October 7, 2014 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 21, 2014

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

RE: Project Number S5597023

Dear Ms. Olson:

On September 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 28, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 22, 2014 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 August 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 7, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 28, 2014, effective October 7, 2014 and therefore remedies outlined in our letter to you dated September 10, 2014, 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5597r14

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245597	A. Building B. Wing	10/13/2014

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/07/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GA/mm	10/21/2014	28034	10/13/2014
Reviewed By CMS RO				

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/28/2014				

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245597	A. Building B. Wing 01 - MAIN BUILDING 01	9/22/2014

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 09/18/2014	ID Prefix Reg. # NFPA 101 LSC K0075	Correction Completed 09/17/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	10/21/2014	27200	09/22/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/27/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245597	02 - ADMINISTRATION ADDITION	9/22/2014

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0052	**09/18/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	10/21/2014	27200	09/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/27/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3NYD
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: **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 **08/28/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **42** (L18)

13. Total Certified Beds **42** (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
	42			
(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
Denise Erickson, HFE NEII
Date: 09/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 10/17/2014 (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
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.
03001
(L31)

30. REMARKS
Posted 10/21/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 10, 2014

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

RE: Project Number S5597023

Dear Ms. Olson:

On August 28, 2014, 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. A 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:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - 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;**

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

<u>Informal Dispute Resolution</u> - 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, Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
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 October 10, 2014, 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 October 10, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (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 November 28, 2014 (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 28, 2015 (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
Division of Compliance Monitoring
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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5597s14

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 ______	08/28/2014

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 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an ongoing program of activities for 1 of 3 residents (R23) reviewed for activities. Findings include: R23's care plan dated 1/4/10, identified diagnoses that included dementia related to hydrocephalus. R23 started on Hospice 10/15/13 for terminal diagnoses of hydrocephalus. R23's quarterly Minimum Data Set (MDS) dated	F 248	Corrective Action: R23 s Care Plan updated on 9/16/14 to reflect past and current interests including goal of staff to attempt personal visit 3-5 times per week offering sensory, verbal and items of personal interest as listed in the Care Plan. Corrective Action as it applies to others: Activity aide educated on 9/15/14 of changes to charting process for all residents of the facility. New process is to	10/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/17/2014

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F 248	Continued From page 1 7/16/14, identified R23 had short and long term memory problems, and severely impaired (never/rarely made decisions) cognitive skills for daily decision making. The MDS further identified R23 required total assistance of two staff for bed mobility, transfers, dressing, personal hygiene and bathing, total assistance of one staff for wheelchair mobility, and extensive assistance of one staff for eating. The Care Area Assessment on Activities dated 11/6/13, indicated R23 was recently admitted to hospice, family visits when able and is receiving extra visitors and support via hospice. R23's Preferences for Customary Routine & Activities/Activity Assessment dated 10/28/13, identified R23 had a past history of reading and enjoyed summer pontoon rides. Facility staff and Hospice staff were to read to him or turn on tv news for him. The activity MDS review completed 7/16/14, indicated R23 continued with no change, continues with Hospice contacts, family visits routinely, and he tries to be alert with their visits. The note also identified as variable with his alertness and participation with eating or reading. R23's care plan dated 1/14/13, indicated past interests in cards, bingo, music, reading, tv, socializing bird watching and animals. Family supplied his simple picture books related to his past interests, R23 is interested in the tv news daily, and staff helps with mail and had set up a reading table as needed. When R23 is alert, staff invites and transports to activities he has accepted, even though he may easily fall asleep when he gets there. R23's participation in activities records were reviewed from 5/1/14, through 8/26/14, and revealed the following:	F 248	include resident responses to activity attempts and evaluations for the need for 1:1 visits will occur in conjunction with MDS assessments. Updates to the care plan will occur as reflected by assessments. Entire facility staff educated via Total Quality Management Communication system on 9/19/14. Reoccurrence will be prevented by: Activity Director will audit the tracking tool for 1 resident each week (may be a different resident each time) x 1 month and then randomly if compliant. Activity Director will report audit findings to the QA committee on a quarterly basis for further direction.	

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F 248	Continued From page 2 5/14: R23 had four visits from the activity department, went outside twice, and received mail seventeen times. 6/14: R23 had two visits from the activity department, went outside once, received a haircut, and received mail fourteen times. 7/14: R23 had three visits from the activity department, had the tv on once, and received mail eighteen times. 8/1-8/26/14: R23 had two visits from the activity department, went outside with family once, had the tv on once, and received mail sixteen times. On 8/25/14, and 8/26/14, R23 was not observed participating in activities. On 8/27/14, at 8:04 a.m. R23 was observed sitting in his room with the tv on, and was looking at magazines. On 8/28/14, R23 was not observed participating in activities. On 8/27/14, at 10:20 a.m. the activity director (AD)-A was interviewed and stated R23 has become less communicative and more sleepy over the years, and it was more of an effort for R23 to participate in an activity due to his hydrocephalus diagnosis. AD-A further stated the activities department see him at meal time, they take him outside, turn on the tv so he can hear the news, and read him the newspaper. They will also read his mail to him if he is awake when they deliver it, and occasionally take him to church. AD-A stated they have not reassessed R23 to determine if there may be other activities of interest to him, and they do not have anyone who can read to him. AD-A stated R23's participation in activities has steadily decreased since 2010. On 8/27/14, at 1:36 p.m. activities aide (AA)-B was interviewed and stated R23's participation in	F 248		

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F 248	Continued From page 3 activities was when the mail came. R23 received a daily newspaper, and if he was awake AA-B would read him the headlines. AA-B stated she spent about 10 minutes with R23 while reading his newspaper/mail. AA-B verified that unless R23's personal activities log stated he had a personal visit, the activities department time spent with R23 was reading his newspaper/mail. The facility was unable to provide a policy and procedure on activities.	F 248		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		10/7/14

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F 441	Continued From page 4 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control surveillance plan to identify,document and monitor resident infections. This had the potential to affect all 36 residents residing in the facility. Findings include: Review of the daily infection control logs from 6/14, through 8/24/14, revealed the facility lacked a system for identifying and tracking resident infections. The daily logs lacked whether the infection was nosocomial (occurred in the facility) acquired, community acquired or chronic, and if a culture was completed to identify specific organisms and appropriate antibiotic use. On 8/2714, at 9:34 a.m. the director of nursing (DON) was interviewed and verified she did not monitor where the infection was acquired, what organism caused the infection, and if a culture was completed. The facility policy and procedure on Infection	F 441	Corrective Action: On 9/5/14 columns were added to the infection control spreadsheet used for tracking. Columns for organisms, and if the infection was nosocomial, community acquired or chronic were added beginning with August 2014. The appropriateness of the antibiotic was also added. Correction as it applies to other residents: A nurses meeting was held on 9/11/14. The infection control policy and procedure regarding infection tracking was reviewed and updates to the monitoring form were explained. Reoccurrence will be prevented by: DON or designee will audit the tracking tool weekly x 4 then monthly for compliance. DON will report audit findings to the QA committee on a quarterly basis for further direction.	

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

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F 441	Continued From page 5 Control Surveillance dated 11/09, directed signs and symptoms of infection are continually monitored, and infections are identified at onset so that appropriate treatment and infection control measures can be put into place to control outbreaks of infectious disease.	F 441		

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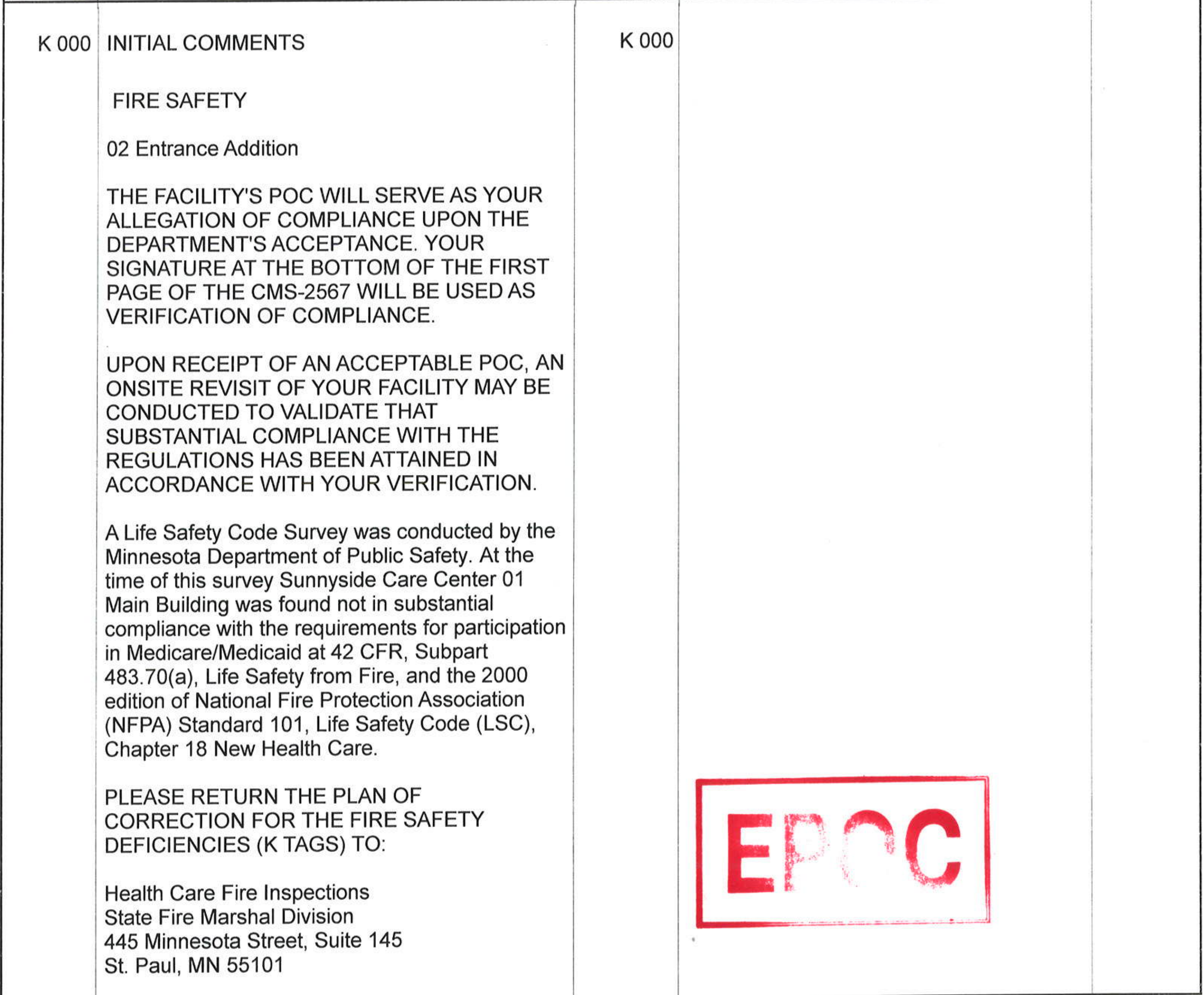
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING **02 - ADMINISTRATION ADDITION** B. WING ______	**08/27/2014**

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



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K 000	INITIAL COMMENTS FIRE SAFETY 02 Entrance Addition 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 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. At the time of this survey Sunnyside Care Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/17/2014

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@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 The facility was surveyed as two buildings: The Sunnyside Care Center is a 1-story building without a basement. The building was constructed in 1975 and is of Type II (000) construction. An entrance and dayroom additions were constructed to the north and south of the original building in 2004 and are Type V (111) construction. The facility is divided into three smoke zones by 1-hour fire barriers. The building is fully sprinkler protected and has a manual fire alarm system with corridor smoke detection and sleeping room smoke detection and also has automatic fire detection in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 43 beds and at the	K 000		

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K 000	Continued From page 2 time of the survey the census was 31 residents. The requirement at 42 CFR, Subpart 483.70(a) in 01 Main Building is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 12:30 PM and 3:30 PM on 08/27/2014, a review of all available fire alarm documentation for the last 12 months, and an interview with the Environmental Director (GZ),	K 052	Corrective Action Correction: All 3 of 12 monthly tests of the DACT that failed occurred on the overnight shift. Overnight shift nurses trained by 9/18/14 by Environmental Services Director on the use of the DACT including how to silence alarms for the comfort of sleeping residents. Environmental Services Director to monitor.	9/18/14

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K 052	Continued From page 3 revealed that at the time of the inspection the facility had failed to conduct 3 of 12 required monthly tests of the DACT for the facility's fire alarm system. This deficient practices was confirmed by the Environmental Director (GZ).	K 052		

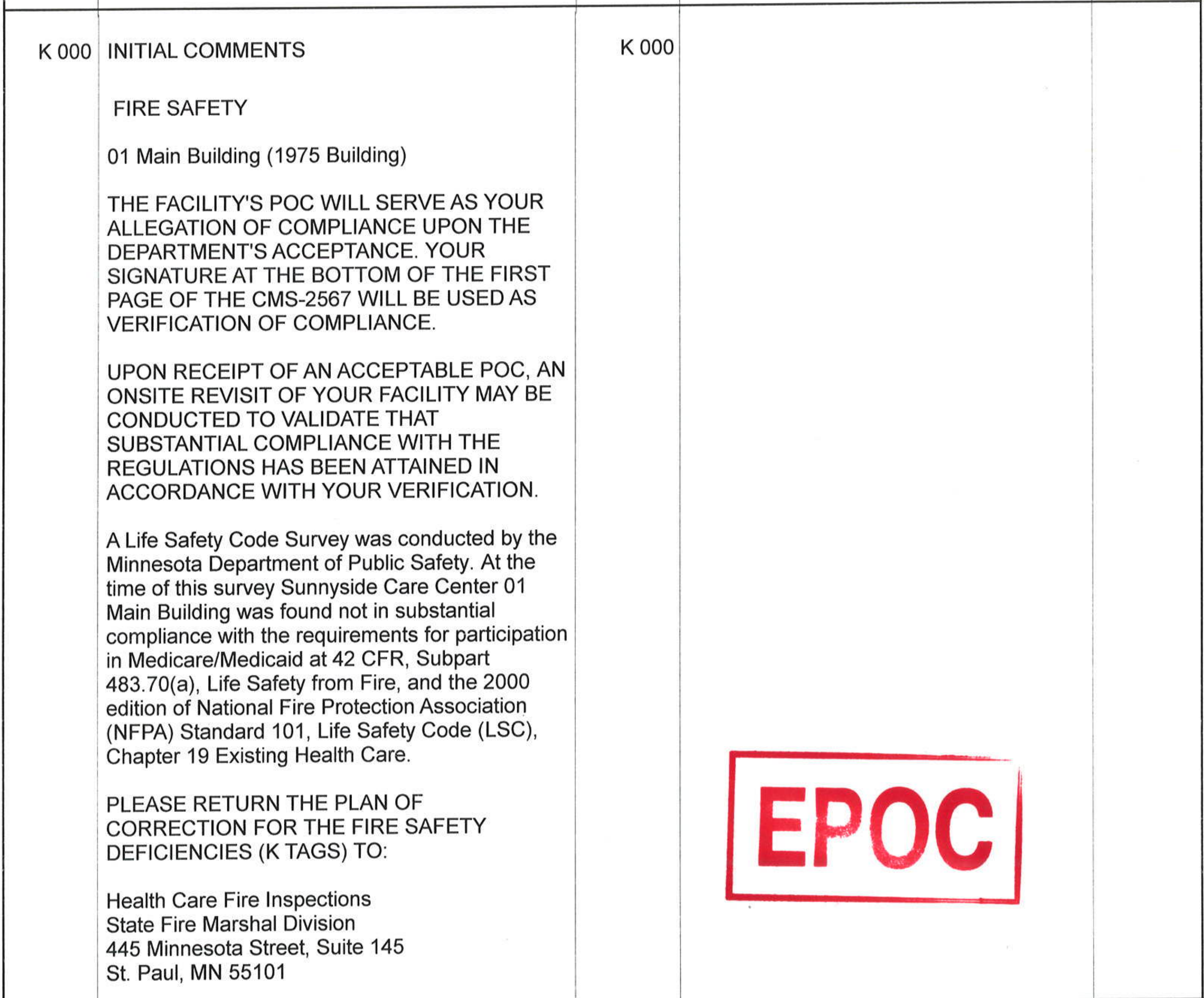
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5597023

PRINTED: 09/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/27/2014**

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



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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building (1975 Building) 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 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. At the time of this survey Sunnyside Care Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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	K 000	EPOC	

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(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 000	Continued From page 2 time of the survey the census was 31 residents. The requirement at 42 CFR, Subpart 483.70(a) in 01 Main Building is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include:	K 052	Corrective Action Correction: All 3 of 12 monthly tests of the DACT that failed occurred on the overnight shift. Overnight shift nurses trained by 9/18/14 by Environmental Services Director on the use of the DACT including how to silence alarms for the comfort of sleeping residents. Environmental Services Director to monitor.	9/18/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/27/2014**

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K 052	Continued From page 3 On facility tour between 12:30 PM and 3:30 PM on 08/27/2014, a review of all available fire alarm documentation for the last 12 months, and an interview with the Environmental Director (GZ), revealed that at the time of the inspection the facility had failed to conduct 3 of 12 required monthly tests of the DACT for the facility's fire alarm system. This deficient practices was confirmed by the Environmental Director (GZ).	K 052		
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of	K 075	Corrective Action Correction: Removal of mobile soiled linen containers with the exception of one (1) 32 gallon container occurred on 9/16/14. Entire facility staff educated on 9/16/14 via TQM.	9/17/14

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	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/27/2014**

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K 075	Continued From page 4 these carts rendered the corridors untenable. Findings include: On facility tour between 12:30 PM and 3:30 PM on 08/27/2014, it was found in that the facility was storing multiple connected mobile solid linen container that are greater than 32 gallons that are being stored in spaces that are greater than 64 square feet (in area) and areas that are open to the corridors and not in the required hazardous storage areas. This deficient practices was confirmed by the Environmental Director (GZ).	K 075	Environmental Services Director to monitor.	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
September 10, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5597023

Dear Ms. Olson:

The above facility was surveyed on August 25, 2014 through August 28, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at: (218) 332-5140 or email: gail.anderson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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 eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00016	A. BUILDING: ______ B. WING ______	08/28/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/17/14

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/28/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control surveillance plan to identify,document and monitor resident infections. This had the potential to affect all 36 residents residing in the facility. Findings include: Review of the daily infection control logs from 6/14, through 8/24/14, revealed the facility lacked a system for identifying and tracking resident infections. The daily logs lacked whether the infection was nosocomial (occurred in the facility) acquired, community acquired or chronic, and if a culture was completed to identify specific organisms and appropriate antibiotic use. On 8/2714, at 9:34 a.m. the director of nursing (DON) was interviewed and verified she did not monitor where the infection was acquired, what organism caused the infection, and if a culture was completed.	21375	Corrective Action: On 9/5/14 columns were added to the infection control spreadsheet used for tracking. Columns for organisms, and if the infection was nosocomial, community acquired or chronic were added beginning with August 2014. The appropriateness of the antibiotic was also added. Correction as it applies to other residents: A nurses meeting was held on September 11th, 2014. The infection control policy and procedure regarding infection tracking was reviewed and updates to the monitoring form were explained. Reoccurrence will be prevented by: DON or designee will audit the tracking tool weekly x 4 then monthly for compliance. DON will report audit findings to the QA committee on a quarterly basis for further direction.	10/7/14

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21375	Continued From page 3 The facility policy and procedure on Infection Control Surveillance dated 11/09, directed signs and symptoms of infection are continually monitored, and infections are identified at onset so that appropriate treatment and infection control measures can be put into place to control outbreaks of infectious disease. Suggested Method of Correction: The director of nursing and/or designee could review and revise policies and procedures related to components of the infection control program and develop a monitoring system to ensure compliance. Time Period For Correction: Twenty one- (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		10/7/14

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21426	Continued From page 4 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a system was in place to document results of tuberculin (TB) skin testing (TST) for 3 of 5 employees (E-A, E-B, E-C) reviewed for TB. Findings include: E-A's first step TST was administered on 6/4/14, and read on 6/7/14, as negative. E-A's second step TST was administered on 6/28/14, and read on 6/30/14, as negative. E-B's second step TST was administered on 7/16/14, and was undated when read as negative. E-C's second step TST was administered on 7/31/14, and read on 8/3/14, as negative. On 8/27/14, at 9:34 a.m., the director of nursing (DON) was interviewed, and verified TST results should be dated when read, and the results should read in millimeters (mm) of induration. The facility policy and procedure on Tuberculin Skin Testing (TST) Protocol directed the following must be documented: date and time test read, exact number of mm of induration (if no induration, document 0 mm). SUGGESTED METHOD OF CORRECTION:	21426	Corrective Action: The form used to track employee TST was changed on 9-4-14. Corrective Action as it applies to others: A nurses meeting was held on 9-11-14. The Employee TB policy and procedure were reviewed and the new monitoring form was explained and demonstrated. The nursing staff are familiar with the form as it is the same form used for the residents. Reoccurrence will be prevented by: DON or designee will audit the tracking tool with each new employee. DON has assigned this task to one Nurse Manager who will assure compliance then file with the business office. This will occur with each new employee x 1 month then randomly if compliant. DON will report audit findings to the QA committee on a quarterly basis for further direction.	

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21426	Continued From page 5 The administrator or designee could review the assessment process for employees to be sure the documentation of the tuberculin tests are completed, the administrator or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21426		
21450	MN Rule 4658.0900 Subp. 4 Activity and Recreation Program; Staff assist Subp. 4. Staff assistance with activities. Sufficient staff must be assigned to assist with the implementation of the activity and recreation program, as determined by the needs of the residents and the nursing home. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an ongoing program of activities for 1 of 3 residents (R23) reviewed for activities. Findings include: R23's care plan dated 1/4/10, identified diagnoses that included dementia related to hydrocephalus. R23 started on Hospice 10/15/13 for terminal diagnoses of hydrocephalus. R23's quarterly Minimum Data Set (MDS) dated 7/16/14, identified R23 had short and long term memory problems, and severely impaired (never/rarely made decisions) cognitive skills for daily decision making. The MDS further identified R23 required total assistance of two staff for bed mobility, transfers, dressing, personal hygiene and bathing, total	21450	Corrective Action: R23 s Care Plan updated on 9/16/14 to reflect past and current interests including goal of staff to attempt personal visit 3-5 times per week offering sensory, verbal and items of personal interest as listed in the Care Plan. Corrective Action as it applies to others: Activity aide educated on 9/15/14 of changes to charting process for all residents of the facility. New process is to include resident responses to activity attempts and evaluations for the need for 1:1 visits will occur in conjunction with MDS assessments. Updates to the care plan will occur as reflected by assessments. Entire facility staff educated via Total Quality Management	10/7/14

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21450	Continued From page 6 assistance of one staff for wheelchair mobility, and extensive assistance of one staff for eating. The Care Area Assessment on Activities dated 11/6/13, indicated R23 was recently admitted to hospice, family visits when able and is receiving extra visitors and support via hospice. R23's Preferences for Customary Routine & Activities/Activity Assessment dated 10/28/13, identified R23 had a past history of reading and enjoyed summer pontoon rides. Facility staff and Hospice staff were to read to him or turn on tv news for him. The activity MDS review completed 7/16/14, indicated R23 continued with no change, continues with Hospice contacts, family visits routinely, and he tries to be alert with their visits. The note also identified as variable with his alertness and participation with eating or reading. R23's care plan dated 1/14/13, indicated past interests in cards, bingo, music, reading, tv, socializing bird watching and animals. Family supplied his simple picture books related to his past interests, R23 is interested in the tv news daily, and staff helps with mail and had set up a reading table as needed. When R23 is alert, staff invites and transports to activities he has accepted, even though he may easily fall asleep when he gets there. R23's participation in activities records were reviewed from 5/1/14, through 8/26/14, and revealed the following: 5/14: R23 had four visits from the activity department, went outside twice, and received mail seventeen times. 6/14: R23 had two visits from the activity department, went outside once, received a haircut, and received mail fourteen times. 7/14: R23 had three visits from the activity	21450	Communication system on 9/19/14. Reoccurrence will be prevented by: Activity Director will audit the tracking tool for 1 resident each week (may be a different resident each time) x 1 month and then randomly if compliant. Activity Director will report audit findings to the QA committee on a quarterly basis for further direction.	

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21450	Continued From page 7 department, had the tv on once, and received mail eighteen times. 8/1-8/26/14: R23 had two visits from the activity department, went outside with family once, had the tv on once, and received mail sixteen times. On 8/25/14, and 8/26/14, R23 was not observed participating in activities. On 8/27/14, at 8:04 a.m. R23 was observed sitting in his room with the tv on, and was looking at magazines. On 8/28/14, R23 was not observed participating in activities. On 8/27/14, at 10:20 a.m. the activity director (AD)-A was interviewed and stated R23 has become less communicative and more sleepy over the years, and it was more of an effort for R23 to participate in an activity due to his hydrocephalus diagnosis. AD-A further stated the activities department see him at meal time, they take him outside, turn on the tv so he can hear the news, and read him the newspaper. They will also read his mail to him if he is awake when they deliver it, and occasionally take him to church. AD-A stated they have not reassessed R23 to determine if there may be other activities of interest to him, and they do not have anyone who can read to him. AD-A stated R23's participation in activities has steadily decreased since 2010. On 8/27/14, at 1:36 p.m. activities aide (AA)-B was interviewed and stated R23's participation in activities was when the mail came. R23 received a daily newspaper, and if he was awake AA-B would read him the headlines. AA-B stated she spent about 10 minutes with R23 while reading his newspaper/mail. AA-B verified that unless R23's personal activities log stated he had a personal visit, the activities department time spent with R23 was reading his newspaper/mail.	21450		

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21450	Continued From page 8 The facility was unable to provide a policy and procedure on activities. Suggested Method of Correction: The activity director or desigee could work with activity staff and/or nursing to arrange and assist residents with activities. The activity director or designee could also perform audits of resident activities to determine if activities are offered. Time Period for Correction: Twenty-one (21) days.	21450		