	AN SERVICES CARE/MEDICAID CERTIFICATION A - TO BE COMPLETED BY THE STAT	ND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: 301X Facility ID: 00776
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245225 2.STATE VENDOR OR MEDICAID NO. (L2) 685740000 	 3. NAME AND ADDRESS OF FACILITY (L3) SLEEPY EYE CARE CENTER (L4) 1105 3RD AVENUE SOUTHWEST (L5) SLEEPY EYE, MN 	(L6) 56085	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 10/29/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual06 PRTF10 NF03 SNF/NF/Distinct07 X-Ray11 ICF/IID04 SNF08 OPT/SP12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATION From (a) : To (b) :	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN	e 1
12 Total Engility Pode (J. 18)	1. Acceptable POC	4. 7-Day RN (Rural SN	(F) 8. Patient Room Size

			Requirements ar	nd/or Applied Waivers:	* Code:	A*	(L12)		
14. LTC CERTIFIED	BED BREAKDOWN				15. FACILI	TY MEETS			
18 SNF	18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1):		(L15)	
	65								
(L37)	(L38)	(L39)	(L42)	(L43)					
16 STATE SURVEY	AGENCY REMARK	S (IF A PPI IC A)	BLE SHOW LTC CAN	CELLATION DATE).	•				

B. Not in Compliance with Program

____ 5. Life Safety Code

9. Beds/Room

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

65 (L18)

65 (L17)

12. Total Facility Beds

13.Total Certified Beds

17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY APPROV	AL Date:
Holly Kranz, Unit Supervisor		12/12/2018 (L19)	Kamala Fiske-Downing, Sr. Healt	h Program Rep 12/12/2018 (L20)
PA	ART II - TO BE COMP	LETED BY HCFA REGIONA	L OFFICE OR SINGLE STATE A	GENCY
19. DETERMINATION OF ELIGIBI 1. Facility is Eligible to 2. Facility is not Eligibility is not Elig	Participate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Financial Solve Ownership/Control Interest I Both of the Above : 	
22. ORIGINAL DATE OF PARTICIPATION 12/01/1978	23. LTC AGREEMENT BEGINNING DATE	24. LTC AGREEMENT ENDING DATE	26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure	(L30) INVOLUNTARY 05 Failte Mart Haakk/Safata
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	 ALTERNATIVE SANC A. Suspension of Admis B. Rescind Suspension 	(L44) Date:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:		(L45) MEDIARY/CARRIER NO.	30. REMARKS	
	03 (L28)	001 (L31)		
31. RO RECEIPT OF CMS-1539	32. DETER	MINATION OF APPROVAL DATE		
	(L32)	(L33)	DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245225

October 30, 2018

Administrator Sleepy Eye Care Center 1105 3rd Avenue Southwest Sleepy Eye, MN 56085

Dear Administrator:

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 17, 2018 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kumalu Fiske Downing

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

cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

October 30, 2018

Administrator Sleepy Eye Care Center 1105 3rd Avenue Southwest Sleepy Eye, MN 56085

RE: Project Number S5225028

Dear Administrator:

On September 17, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on September 7, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 29, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 17, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 7, 2018, effective October 17, 2018 and therefore remedies outlined in our letter to you dated September 17, 2018, 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.

Sincerely,

Kumalu Fish Downing

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

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

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MEDICARE/MEDICAID CERTIFICATIO	N AND TRANSMITTAL
ΔΑ DT L ΤΟ DE COMDIETED DV THE S'	TATE SUDVEV ACENCY

ID: 301X

PART I	- TO BE COMPLETED BY THE ST	ATE SURVEY AGENCY	Facility ID: 00776
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245225 2.STATE VENDOR OR MEDICAID NO. (L2) 685740000	3. NAME AND ADDRESS OF FACILITY (L3) SLEEPY EYE CARE CENTER (L4) 1105 3RD AVENUE SOUTHWEST (L5) SLEEPY EYE, MN	(L6) 56085	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESR	<u>02</u> (L7) D 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 09/07/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/J 04 SNF 08 OPT/SP 12 RHC		FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 65 (L18) 13.Total Certified Beds	 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 	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
	Requirements and/or Applied Waivers:	* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOWN	·	15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF 65	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	ABLE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Wendy Buckholz, HFE NE II HFE NE II	10/01/2018 (L19)	Kamala Fiske-Downing,	Sr. Health Program Rep 10/12/2018 (L20)
PART II - TO BE	COMPLETED BY HCFA REGIONA	AL OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) 2 :
22. ORIGINAL DATE 23. LTC AGREE	EMENT 24. LTC AGREEMENT	26. TERMINATION ACTION	(L30)
OF PARTICIPATION BEGINNIN 12/01/1978	G DATE ENDING DATE	VOLUNTARY 00 01-Merger, Closure 00	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE: 27. ALTERNAT	IVE SANCTIONS	03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	OTHER
A. Suspensio	on of Admissions:	04-Other Reason for withdrawal	07-Provider Status Change 00-Active
(L27) B. Rescind S	(L44) Suspension Date: (L45)		
28. TERMINATION DATE: 2	9. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	03001		
(L28)	(L31)		
31. RO RECEIPT OF CMS-1539 3	2. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 17, 2018

Sleepy Eye Care Center Attn: Administrator 1105 3rd Avenue Southwest Sleepy Eye, MN 56085

RE: Project Number S5225028

Dear Administrator:

On September 7, 2018, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001 Email: holly.kranz@state.mn.us Phone: (507) 344-2742 Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 17, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 7, 2018 (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 March 7, 2019 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		C	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245225	B. WING _			09/	07/2018
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER				5 3RD AVENUE SOUTHWEST EEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00			
F 000	Emergency Prepare conducted on 9/4/1 recertification surve	ey. The facility is in compliance Cemergency Preparedness	F 00	00			
	completed at your f Department of Hea was in compliance	a standard survey was acility by the Minnesota Ith to determine if your facility with the requirements of 42 part B, and Requirements for icilities.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are rour signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.					
F 756 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Drug Regimen Rev	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with iew, Report Irregular, Act On 1)(2)(4)(5)	F 75	56			10/17/18
	must be reviewed a licensed pharmacis	drug regimen of each resident It least once a month by a t.					
	§483.45(c)(2) This	review must include a review					
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						09/27/2018

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.

PRINTED: 10/01/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/01/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245225	B. WING			09/0	07/2018
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER				105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	irregularities to the facility's medical dir and these reports n (i) Irregularities inc drug that meets the (d) of this section fo (ii) Any irregularities during this review n separate, written re attending physician director and directo minimum, the resid and the irregularity (iii) The attending p resident's medical n irregularity has been action has been tak be no change in the physician should do the resident's medical §483.45(c)(5) The f maintain policies and drug regimen review limited to, time fram the process and ste when he or she idea requires urgent acti This REQUIREMEN by: Based on interview facility failed to ensu- the lack of paramet needed (PRN) pain resident (R48) review	edical chart. bharmacist must report any attending physician and the ector and director of nursing, nust be acted upon. lude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug. a noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical r of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. hysician must document in the ecord that the identified n reviewed and what, if any, ten to address it. If there is to a medication, the attending boument his or her rationale in	1	756	It is the policy of the Sleepy Eye Ca Center to ensure that the drug regir each resident is reviewed at least o month by a licensed pharmacist an ensure the pharmacist reports any	men of Ince a d to	
	needed (PRN) pain	medications for 1 of 5			month by a licensed pharmacist an	d to	

Facility ID: 00776

If continuation sheet Page 2 of 10

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			OM	B NO.	APPROVEE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()		SURVEY PLETED
		245225	B. WING			09/0	7/2018
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SLEEPY	EYE CARE CENTER				105 3RD AVENUE SOUTHWEST LEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From pa	ge 2	F 7	56			
	Findings include:				and the facility's medical director and director of nursing.	b	
		ated 9/7/18 included a			Resident #48		
diagnosis of pain. R48's current phys included: acetamin minor aches and p (650 milligrams) by needed (PRN) for p pain medicine for n milligrams (mg) tak every 4 hours PRN The admission Min	imum Data Set (MDS) 8/16/18, identified R48 as			Reviewed resident medical record. Oxycodone was discontinued on 9/6/2018. Received order on 9/8/201 Hydrocodone-Acetaminophen 5-325 give 1 tablet by mouth every 4 hours needed for low back pain. Give Tyler pain 1-4, give 1 tab of Hydrocodone pain 5-8. Give 2 tabs of Hydrocodone pain 9-10. All resident charts were reviewed to ensure that all prn pain medications	mg as nol for for e for		
	score of 13 indicatin also indicated R48 on a 1-10 pain scale 3-4= moderate pain severe pain, 9-10=	view for Mental Status (BIMS) ng intact cognition. The MDS had frequent pain rating it a 10 e (0= no pain, 1-2= mild pain, n, 5-6= severe pain, 7-8= very worst possible) and required			prescribed correctly and updated as necessary. The Director of Nursing and the cons pharmacist reviewed the policies and procedures for proper monitoring of		
	transfers, dressing, hygiene.	e of staff with bed mobility, toilet use, and personal			medication usage. The nursing staff will be educated on Monday October 1st on the importan		
	focus for pain relate Interventions includ per physician order and use of non-mee humor, relaxation, c	t revised on 8/27/18 included a ed to recent surgery. led to administer medication , monitor pain characteristics dicinal interventions such a distraction, imagery ge, music, heat, cold.			the pharmacist's review. The Director of Nursing will audit 10 residents charts weekly x4 weeks to ensure prn pain medications orders a prescribed correctly. Results to be sh with consulting pharmacist.	are	
	dated August 26-31 received 1 dose of	dministration record (MAR) st 2018, identified R48 PRN acetaminophen for pain scale and 12 does of the PRN			The Director of Nursing is responsibl overall compliance along with communicating results of audits to th QAPI Committee.		

Facility ID: 00776

If continuation sheet Page 3 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUIT	IPLF	CONSTRUCTION		0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
245225		B. WING _			09/07/2018		
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER				05 3RD AVENUE SOUTHWEST EEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 756	Continued From pa	age 3	F 75	56			
	· ·	rated 0-10 on pain scale.					
	identified R48 rece acetaminophen for	September 1-7th 2018, ived 8 doses of PRN pain rated 3-10 and 17 doses for pain rated 4-10 on pain			The facility alleges that it will be in substantial compliance and comp action items by October 17, 2018.	lete all	
	was sitting on edge not know what pair did not ask for then she couldn't tell the	n 9/7/18, at 12:06 p.m. R48 e of bed. She stated she did n medications she receives and n by name. R48 further stated e difference between them always in some sort of pain.					
	registered nurse (F judgement" to deci administer to R48. usually rated her pa so would give 2 oxy between to "hold he are parameters on orders lacked para	n 9/7/18, at 3:09 p.m. RN)-A stated she uses "nursing de which pain medication to RN-A further explained R48 ain a 10 (on 1-10 pain scale) ycodone and acetaminophen in er". RN-A stated usually there orders but confirmed R48's meters related to cetaminophen vs. oxycodone.					
1		mmendations for parameters hophen and oxycodone 1-2 R48.					
	of nursing (DON) s of when to adminis pharmacist did not	n 9/7/18, at 3:17 p.m. director tated there should be a range ter medication and verified the address the lack of N pain medications.					
	consultant pharma	n 9/7/18, at 3:49 p.m. cist indicated he would expect o have parameters and					

Facility ID: 00776

If continuation sheet Page 4 of 10

		AND HUMAN SERVICES				FORM	10/01/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245225	B. WING			09/	07/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SLEEPY	EYE CARE CENTER				105 3RD AVENUE SOUTHWEST LEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 756 F 757 SS=D	confirmed he had r monthly visit. A facility policy titled Contract Addendum the consultant shall care plan for each r monthly drug regim pharmaceutical car the purpose of iden potential drug probl to drug therapy and Dept of Health/Boa regulations. The co written report discus suggestions, and in the monthly review. Drug Regimen is Fr CFR(s): 483.45(d)(§483.45(d) Unnece Each resident's dru unnecessary drugs drug when used- §483.45(d)(1) In ex duplicate drug thera §483.45(d)(2) For ea §483.45(d)(3) Withe §483.45(d)(4) Withouse; or §483.45(d)(5) In the	d, Pharmaceutical Consulting n 2017, dated 1/1/17, identified I prepare a pharmaceutical resident and shall perform a ten review of each resident's te plan and personal record for tifying drug problems, lems, and irregularities related d compliance with CMS/MN rd of Pharmacy rules and onsultant shall prepare a ssing all problems, regularities identified during ree from Unnecessary Drugs 1)-(6) essary Drugs-General. tg regimen must be free from . An unnecessary drug is any cessive dose (including apy); or excessive duration; or out adequate monitoring; or out adequate indications for its e presence of adverse ch indicate the dose should be	F 7				10/17/18

If continuation sheet Page 5 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039 (X3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED
	245225 B. WING			09/07/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SLEEPY	EYE CARE CENTER			1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIO
F 757	Continued From pa	ge 5	F 75	7	
	stated in paragraph section. This REQUIREMEN by: Based on interview failed to identify par pain medications fo unnecessary medic Findings include: R48's face sheet da diagnosis of pain. R48's current physic included: acetamin minor aches and pa (650 milligrams) by needed (PRN) for p pain medicine for m milligrams (mg) take every 4 hours PRN The admission Mini assessment dated 8 having a Brief Intervision score of 13 indicatir also indicated R48 I on a 1-10 pain scale 3-4= moderate pain severe pain, 9-10=	ated 9/7/18 included a cian orders dated 9/7/18 ophen (a pain medicine for ins) liquid 20.3 milliliters (ml) mouth (PO) every 4 hours as ain and oxycodone (a narcotic oderate to severe pain) 5 e 1-2 tablets (5-10 mg) PO		It is the policy of the Sleepy Eye Center to ensure that each reside regimen is free from unnecessary Resident #48 Reviewed resident medical record Oxycodone was discontinued on 9/6/2018. Received order on 9/8/2 Hydrocodone-Acetaminophen 5-3 give 1 tablet by mouth every 4 ho needed for low back pain. Give Ty pain 1-4, give 1 tab of Hydrocodo pain 5-8. Give 2 tabs of Hydrocodo pain 9-10. All resident charts were reviewed ensure that all prn pain medicatio prescribed correctly and updated necessary. The Director of Nursing and the of pharmacist reviewed the policies procedures for proper monitoring medication usage. The nursing staff will be educated Monday October 1st on the import the pharmacist's review and the importance of parameters with Pf	ent's drug y drugs. d. 2018 for 325mg urs as ylenol for ne for lone for to ns were as consulting and of d on tance of

Facility ID: 00776

If continuation sheet Page 6 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		<u>0938-039</u> E SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	COMPLETED	
		245225	B. WING		09/07/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E		
SLEEPY	EYE CARE CENTER		1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 757	per physician order and use of non-me humor, relaxation, techniques, massa R48's medication a dated August 26-31 received 1 dose of rated a 10 on pain oxycodone for pain R48's MAR dated S identified R48 rece acetaminophen for of PRN oxycodone scale. During interview on was sitting on edge not know what pain did not ask for then she couldn't tell the indicating she was During interview on registered nurse (F judgement" to decid administer to R48. usually rated her pa so would give 2 oxy between to "hold he are parameters on orders lacked para administration of ac	ded to administer medication r, monitor pain characteristics dicinal interventions such a distraction, imagery ge, music, heat, cold. administration record (MAR) 1st 2018, identified R48 PRN acetaminophen for pain scale and 12 does of the PRN rated 0-10 on pain scale. September 1-7th 2018, ived 8 doses of PRN pain rated 3-10 and 17 doses for pain rated 4-10 on pain 9/7/18, at 12:06 p.m. R48 e of bed. She stated she did medications she receives and n by name. R48 further stated e difference between them always in some sort of pain. 9/7/18, at 3:09 p.m. RN)-A stated she uses "nursing de which pain medication to RN-A further explained R48 ain a 10 (on 1-10 pain scale) ycodone and acetaminophen in er". RN-A stated usually there orders but confirmed R48's	F 757	 residents' charts weekly x4 wee ensure prn pain medications or prescribed correctly. Results to with consulting pharmacist. The Director of Nursing is resp overall compliance along with communicating results of audits QAPI Committee. The facility alleges that it will be substantial compliance and cor action items by October 17, 20 	ders are be shared onsible for s to the in nplete all		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245225	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	240220	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	07/2018
	EYE CARE CENTER		1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 757 F 761 SS=D	medications. The the order be clarifie time of receipt.	for R48's PRN pain DON stated her expectation is d to include parameters at and Biologicals	F 75			10/17/18
	Drugs and biologica labeled in accordan professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted ales, and include the ory and cautionary e expiration date when				
	§483.45(h) Storage	of Drugs and Biologicals				
	Federal laws, the fa biologicals in locked	cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized access to the keys.				
	locked, permanently storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected. This REQUIREMEN	facility must provide separately y affixed compartments for d drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced				
	review the facility fa were dated when o	tion, interview and document ailed to ensure medications pened and removed from room/refrigerator when		It is the policy of the Sleepy Eye C Center to provide pharmaceutical to meet the needs of each residen	services	

Facility ID: 00776

If continuation sheet Page 8 of 10

		& MEDICAID SERVICES	1				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245225	B. WING			09/0	07/2018
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER				105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 761	Continued From pa	age 8	F7	761			
	expired in 1 of 2 me	expired in 1 of 2 medication carts, 1 of 1 medication room and 1 of 1 medication			Resident #31		
	refrigerator. Findings include:				Expired medication, Breo-Ellipta inf was disposed of as soon as expirat was identified.		
	R31's signed physician orders dated 8/29/18, included an order for Breo Ellipta aerosol powder breath activated inhaler 200-25 mcg/inh (micrograms/inhalation) (fluticasone				Glutose gel and Pneumovax vaccin were disposed of as soon as expira was identified.		
	day related to chroi	I puff inhale orally one time a nic obstructive pulmonary r was dated 6/11/18 with a 8.			All medications in medication carts stock and ER medications were rev for expiration dates. Outdated medications were removed.		
	hall 3 was observed (LPN)-A. The cont Breo Ellipta 200/25	p.m. the medication cart for d with licensed practical nurse ents of the cart included one mcg/inh inhaler and one Breo /inh inhaler. The Breo Ellipta			The Director of Nursing and the cor pharmacist reviewed the policies ar procedures for proper storage and monitoring of medication usage.		
	100-25 mcg/inh inh when the inhaler ha there were 4 doses physician orders ar inhaler had change	aler was undated related to ad been opened, and indicated s left. LPN-A checked R31's and verified the dose of the ed. LPN-A was unable to tell if			The nursing staff will be educated of Monday October 1st on the importar removing expired medications from medication carts, medication room refrigerator.	ince of	
	pharmacy label ind LPN-A verified the inhaler was both dis still remained on th	naler was expired though the icated it was issued in 2017. Breo Ellipta 100-25 mcg dose scontinued and expired though e medication cart. LPN-A was			A monthly schedule of checking medication carts for expired medica was developed for nursing staff.	ations	
	discontinuation and	he inhaler had been used since d was unaware that the dosing were different stating, "I guess e different".			The Director of Nursing will check medications carts for expired medic bimonthly. Results to be shared wit consulting pharmacist.		
	observed with LPN emergency kit inclu	p.m. the medication room was -B. Contents of the Ided a package of 2 Glutose with an expiration date of			The Director of Nursing is responsil overall compliance along with communicating results of audits to QAPI Committee.		

Facility ID: 00776

		AND HUMAN SERVICES				FORM	10/01/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245225	B. WING			09/	07/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER				105 3RD AVENUE SOUTHWEST LEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	 8/14/17. LPN-B co was expired. On 9/7/18, at appro- medication refrigera observed with LPN- medication refrigera 23 pneumococcal w dated of 7/12/18. L was expired. The Pharmaceutica Manual revised Dee Discontinued Medic have had their order removed from the r placed in a specifie medication room un medications shall b 	nfirmed the the glucose gel eximately 2:20 p.m. the locked ator located on hall one was	F	761	The facility alleges that it will be in substantial compliance and comple action items by October 17, 2018.	ete all	

Facility ID: 00776

If continuation sheet Page 10 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	10	222022		APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - SLEEPY EYE CARE CENTER	(X3) DATE SU COMPLE	
245225	B. WING		09/07	/2018
SLEEPY EYE CARE CENTER 1105 3		BTATE, ZIP CODE E SOUTHWEST I 56085		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 000 INITIAL COMMENTS	K 000			
 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Sleepy Eye Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Sleepy Eye Care Center is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(000) construction. In 1985, addition was constructed and was determined to be of Type II(000) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 52 at time of the survey. 				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	BNATURE	TITLE		(X6) DATE

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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2018

Sleepy Eye Care Center Attn: Administrator 1105 3rd Avenue Southwest Sleepy Eye, MN 56085

Re: Project Number S5225028

Dear Administrator:

The above facility was surveyed on September 4, 2018 through September 7, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Holly Kranz, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001 Email: holly.kranz@state.mn.us Phone: (507) 344-2742 Fax: (507) 344-2723

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.

Please feel free to call me with any questions.

Sincerely,

Kumala Fish Downing

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

cc: Licensing and Certification File

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00776	B. WING		09/0	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER		AVENUE SO EYE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 09/27/18

Electronically Signed STATE FORM

If continuation sheet 1 of 12

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00776	B. WING		09/	09/07/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•		
SLEEPY	EYE CARE CENTER		O AVENUE SOL EYE, MN 5608				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm On 9/4 - 9/7/18, sur staff, visited the ab correction orders a your electronic plar reviewed these ord they will be comple Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag m column entitled "IE statute/rule out of co "Summary Stateme and replaces the "T correction order. Th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. rveyors of this Department's ove provider and the following re issued. Please indicate in n of correction that you have ers, and identify the date wher					
	are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	wing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.					

301X11

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		00776	B. WING		09/07/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
SLEEPY	EYE CARE CENTER		AVENUE SO EYE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 000	Continued From page	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
21530	MN Rule 4658.1310	A.B.C Drug Regimen Review	21530			10/17/18
	reviewed at least m currently licensed by This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not sul B. The pharmad irregularities to the of and the attending pl must be acted upon physician visit, or so pharmacist. For pu upon" means the act report and the signified of nursing services C. If the attendi with the pharmacist not provide adequat pharmacist believes being adversely affer refer the matter to the if the medical direct physician. If the me the attending physic justification for the of	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ng-Term Care, published by dealth and Human Services, ing Administration, April 1992. corporated by reference. It is e Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports by the time of the next boner, if indicated by the rposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ng physician does not concur 's recommendation, or does te justification, and the s the resident's quality of life is exted, the pharmacist must he medical director for review or is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter				

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00776	B. WING		09/07/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
SLEEPY	EYE CARE CENTER		AVENUE S EYE, MN 56	OUTHWEST 6085	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
TAG 21530	Continued From para must be referred for assessment and as by part 4658.0070. the medical director must refer the matt assessment and as This MN Requirem by: Based on interview facility failed to ensist the lack of paramet needed (PRN) pain resident (R48) revie medications. R48's face sheet da diagnosis of pain. R48's current physi included: acetamin minor aches and pai (650 milligrams) by needed (PRN) for p pain medicine for n milligrams (mg) tak every 4 hours PRN The admission Min assessment dated having a Brief Inter score of 13 indicati also indicated R48 on a 1-10 pain scal	age 3 r review to the quality ssurance committee required If the attending physician is pr, the consulting pharmacist ter directly to the quality ssurance committee. ent is not met as evidenced and document review the ure the pharmacist addressed ters for administration of as medications for 1 of 5 ewed for unnecessary ated 9/7/18 included a ician orders dated 9/7/18 hophen (a pain medicine for ains) liquid 20.3 milliliters (ml) mouth (PO) every 4 hours as bain and oxycodone (a narcotic noderate to severe pain) 5 te 1-2 tablets (5-10 mg) PO for pain. imum Data Set (MDS) 8/16/18, identified R48 as view for Mental Status (BIMS) ng intact cognition. The MDS had frequent pain rating it a 10 e (0= no pain, 1-2= mild pain,	21530		n of e a 0 0 18. g s I for r for
nosota D	severe pain, 9-10= extensive assistance	n, 5-6= severe pain, 7-8= very worst possible) and required ce of staff with bed mobility, , toilet use, and personal		The Director of Nursing and the consu pharmacist reviewed the policies and procedures for proper monitoring of medication usage.	lting

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00776	B. WING		09/0	7/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER		AVENUE S YE, MN 56	OUTHWEST 6085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	ge 4	21530			
	focus for pain relate Interventions includ per physician order and use of non-met humor, relaxation, of techniques, massag R48's medication a dated August 26-31 received 1 dose of rated a 10 on pain s oxycodone for pain R48's MAR dated S identified R48 recei acetaminophen for of PRN oxycodone scale. During interview on was sitting on edge not know what pain did not ask for them she couldn't tell the indicating she was During interview on registered nurse (R judgement" to decid administer to R48. usually rated her pa so would give 2 oxy between to "hold he are parameters on orders lacked parar administration of ad	ge, music, heat, cold. dministration record (MAR) st 2018, identified R48 PRN acetaminophen for pain scale and 12 does of the PRN rated 0-10 on pain scale. September 1-7th 2018, ved 8 doses of PRN pain rated 3-10 and 17 doses for pain rated 4-10 on pain 9/7/18, at 12:06 p.m. R48 of bed. She stated she did medications she receives and h by name. R48 further stated difference between them always in some sort of pain. 9/7/18, at 3:09 p.m. N)-A stated she uses "nursing de which pain medication to RN-A further explained R48 ain a 10 (on 1-10 pain scale) vcodone and acetaminophen in er". RN-A stated usually there orders but confirmed R48's		The nursing staff will be edu Monday October 1st on the the pharmacist□s review. The Director of Nursing will residents charts weekly x4 we ensure prn pain medications prescribed correctly. Result with consulting pharmacist. The Director of Nursing is re overall compliance along wit communicating results of at QAPI Committee. The facility alleges that it wi substantial compliance and action items by October 17,	importance of audit 10 weeks to s orders are s to be shared esponsible for th udits to the II be in complete all	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00776	B. WING		09/	07/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SI FFPY	EYE CARE CENTER		AVENUE SO			
		SLEEPY E	EYE, MN 560	85		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ge 5	21530			
	related to acetamin tabs was noted for	ophen and oxycodone 1-2 R48.				
	of nursing (DON) si of when to administ pharmacist did not parameters for PRM During interview on consultant pharmac pain medications to confirmed he had n monthly visit.	N pain medications. 9/7/18, at 3:49 p.m. cist indicated he would expect b have parameters and not identified this on his d, Pharmaceutical Consulting				
	the consultant shall care plan for each i monthly drug regim pharmaceutical car the purpose of iden potential drug probl to drug therapy and Dept of Health/Boa regulations. The co written report discu	regularities identified during				
	The administrator, of consulting pharmac policies and proced medication usage. educated as necess pharmacist's review with the pharmacist	THOD OF CORRECTION: director of nursing (DON) and cist could review and revise lures for proper monitoring of Nursing staff could be sary to the importance of the v. The DON or designee, along t, could audit medication ar basis to ensure compliance.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		ATE SURVEY OMPLETED	
		00776	B. WING		09/07/2018		
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
LEEPY	EYE CARE CENTER		AVENUE SO EYE, MN 560				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLET DATE	
21530	Continued From pa	ge 6	21530				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one					
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary ral	21535			10/17/18	
	must be free from u unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the preserving which indicate the o discontinued. In addition to the d part 4658.1310, the with provisions in the Code of Federal Ree 483.25 (1) found in Operations Manual Long-Term Care Fat	al. A resident's drug regimen innecessary drugs. An s any drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for acilities, published by the lth and Human Services,					
	Health Care Financ This standard is inc available through th	ing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not					
	by: Based on interview failed to identify par	ent is not met as evidenced and record review the facility rameters for as needed (PRN) or 1 of 5 (R48) reviewed for rations.		It is the policy of the Sleepy Eye Center to ensure that each reside drug regimen is free from unnece drugs.	ent⊡s		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00776	B. WING		09/07	7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER		AVENUE SO EYE, MN 56	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
21535	Continued From pa	ge 7	21535			
		ated 9/7/18 included a		Resident #48		
	included: acetamin minor aches and pa (650 milligrams) by needed (PRN) for p pain medicine for m milligrams (mg) tak every 4 hours PRN The admission Mini assessment dated having a Brief Intern score of 13 indicatin also indicated R48 on a 1-10 pain scal 3-4= moderate pain severe pain, 9-10= extensive assistant transfers, dressing, hygiene. R48's care plan las focus for pain relate Interventions includ per physician order and use of non-med humor, relaxation, o techniques, massage R48's medication a dated August 26-31 received 1 dose of	imum Data Set (MDS) 8/16/18, identified R48 as view for Mental Status (BIMS) ng intact cognition. The MDS had frequent pain rating it a 10 e (0= no pain, 1-2= mild pain, n, 5-6= severe pain, 7-8= very worst possible) and required e of staff with bed mobility, toilet use, and personal t revised on 8/27/18 included a ed to recent surgery. led to administer medication , monitor pain characteristics dicinal interventions such a		 Reviewed resident medical record Oxycodone was discontinued on a Received order on 9/8/2018 for Hydrocodone-Acetaminophen 5-3 give 1 tablet by mouth every 4 hor needed for low back pain. Give Ty pain 1-4, give 1 tab of Hydrocodo pain 5-8. Give 2 tabs of Hydrocodo pain 9-10. All resident charts were reviewed ensure that all prn pain medicatio prescribed correctly and updated necessary. The Director of Nursing and the c pharmacist reviewed the policies a procedures for proper monitoring medication usage. The nursing staff will be educated Monday October 1st on the import the pharmacist_s review and the importance of parameters with PF medications. The Director of Nursing will audit residents_ charts weekly x4 week ensure prn pain medications orde prescribed correctly. Results to be with consulting pharmacist. The Director of Nursing is responsoverall compliance along with 	9/6/2018. 25mg urs as /lenol for ne for one for to ns were as onsulting and of l on tance of RN 10 ks to rs are e shared	
		rated 0-10 on pain scale. September 1-7th 2018,		communicating results of audits to QAPI Committee.	o the	
		ved 8 doses of PRN		The facility alleges that it will be in	ı	

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		00776	B. WING		09/	07/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SLEEPY	EYE CARE CENTER		AVENUE SO EYE, MN 56	OUTHWEST 085		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 8	21535			
	acetaminophen for pain rated 3-10 and 17 doses of PRN oxycodone for pain rated 4-10 on pain scale. During interview on 9/7/18, at 12:06 p.m. R48 was sitting on edge of bed. She stated she did not know what pain medications she receives and did not ask for them by name. R48 further stated she couldn't tell the difference between them indicating she was always in some sort of pain.			substantial compliance an action items by October 1		
	registered nurse (R judgement" to decid administer to R48. usually rated her pa so would give 2 oxy between to "hold he are parameters on orders lacked param	9/7/18, at 3:09 p.m. N)-A stated she uses "nursing de which pain medication to RN-A further explained R48 ain a 10 (on 1-10 pain scale) ycodone and acetaminophen in er". RN-A stated usually there orders but confirmed R48's meters related to cetaminophen vs. oxycodone.				
	of nursing (DON) st of when to administ lack of parameters medications. The	9/7/18, at 3:17 p.m. director tated there should be a range ter medication and verified the for R48's PRN pain DON stated her expectation is ed to include parameters at				
	director of nursing (conjunction with the develop policies an monitoring of pro re parameters, and m DON could educate changes in policy a resident records to	THOD OF CORRECTION: The (DON) could work in e consultant pharmacist to d procedures related to e nata (PRN) medication use, onitoring of effectiveness. The e staff related to these nd procedure, and audit ensure process changes are ults of audits could be reported				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3) DATE COMP	SURVEY	
		00776	B. WING		07/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
SLEEPY	EYE CARE CENTER		AVENUE S EYE, MN 56	OUTHWEST 5085	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
21535	Continued From pa	ige 9	21535		
		ance committee for further to ensure ongoing compliance.			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
21620	MN Rule 4658.134	5 Labeling of Drugs	21620		10/17/18
	Drugs used in the r in accordance with	nursing home must be labeled part 6800.6300.			
	by: Based on observati review the facility fa were dated when of medication carts or expired in 1 of 2 me medication room ar refrigerator. Findings include: R31's signed physic included an order fo breath activated inh (micrograms/inhala furoate-vilanterol) 1 day related to chror disease. The order start date of 6/12/18 On 9/4/18, at 6:45 p hall 3 was observed (LPN)-A. The conte Breo Ellipta 200/25	puff inhale orally one time a nic obstructive pulmonary r was dated 6/11/18 with a		It is the policy of the Sleepy Eye Care Center to provide pharmaceutical services to meet the needs of each resident. Resident #31 Expired medication, Breo-Ellipta inhaler was disposed of as soon as expiration was identified. Glutose gel and Pneumovax vaccination were disposed of as soon as expiration was identified. All medications in medication carts and stock and ER medications were reviewed for expiration dates. Outdated medications were removed. The Director of Nursing and the consulting pharmacist reviewed the policies and procedures for proper storage and monitoring of medication usage.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00776	B. WING		09/0	7/2018
		1105 3RD SLEEPY E	DRESS, CITY, S AVENUE SC EYE, MN 56	085 PROVIDER'S PLAN OF CORR		(X5)
(X4) ID PREFIX TAG 21620	(EACH DEFICIENCY REGULATORY OR LA Continued From pa 100-25 mcg/inh inh when the inhaler ha there were 4 doses physician orders an inhaler had change the 100-25 mcg inh pharmacy label indi LPN-A verified the f inhaler was both dis still remained on the unable to verify if th discontinuation and of the two inhalers of they (the doses) are On 9/7/18, at 1:56 p observed with LPN- emergency kit inclu 15 oral glucose gel 8/14/17. LPN-B co was expired. On 9/7/18, at appro medication refrigera observed with LPN- medication refrigera observed with LPN- medication refrigera 23 pneumococcal v dated of 7/12/18. L was expired. The Pharmaceutica Manual revised Dec Discontinued Medic have had their order removed from the r placed in a specifie	ge 10 aler was undated related to d been opened, and indicated left. LPN-A checked R31's d verified the dose of the d. LPN-A was unable to tell if aler was expired though the cated it was issued in 2017. Breo Ellipta 100-25 mcg dose scontinued and expired though e medication cart. LPN-A was the inhaler had been used since was unaware that the dosing were different stating, "I guess e different". D.m. the medication room was B. Contents of the ded a package of 2 Glutose with an expiration date of nfirmed the the glucose gel eximately 2:20 p.m. the locked ator located on hall one was	ID PREFIX TAG 21620	 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY) The nursing staff will be educa Monday October 1st on the im removing expired medications medication carts, medication of refrigerator. A monthly schedule of checkin medication carts for expired m was developed for nursing sta The Director of Nursing will ch medications carts for expired bimonthly. Results to be shar consulting pharmacist. The Director of Nursing is respoverall compliance along with communicating results of aud QAPI Committee. The facility alleges that it will b substantial compliance and co action items by October 17, 20 	ADULD BE PROPRIATE	(X5) COMPLET DATE

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00776	B. WING		09/	07/2018
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
LEEPY	EYE CARE CENTER		DAVENUE SOU EYE, MN 5608			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
21620	Continued From pa	ge 11	21620			
	SUGGESTED MET	HODS OF CORRECTION:				
	The Director of Nursing (DON) or designee could develop, review, and/or revise policies and					
	procedures to ensu	re expired medications are no)			
	longer in use. The Director of Nursing Services or designee					
	could educate all appropriate staff on the policies					
	and procedures. The Director of Nursing Services or designee					
	could develop monion ongoing compliance	itoring systems to ensure				
	TIME PERIOD FOR Twenty-One (21) D					