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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6FSW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00338

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245357**

2.STATE VENDOR OR MEDICAID NO.
(L2) **599245100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNRISE MANOR NURSING HOME**
(L4) **240 WILLOW STREET**
(L5) **TYLER, MN** (L6) **56178**

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 **12/12/2013** (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)
02/28

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

12.Total Facility Beds **38** (L18)

13.Total Certified Beds **38** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	38			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Connie Brady, HFE NE II — 01/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 2/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(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
01/29/2014
(L33)

DETERMINATION APPROVAL

CCN-245357

On January 30, 2014 a Post Certification Revisit (PCR) was completed by the Department of Health and on February 3, 2014, the Minnesota Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the December 12, 2013, standard survey, effective January 21, 2014. Refer to the CMS 2567b for both health and life safety code.

Effective January 21, 2014, the facility is certified for 38 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245357

February 6, 2014

Ms. Kathleen Roesch-Miranowski, Administrator
Sunrise Manor Nursing Home
240 Willow Street
Tyler, MN 56178

Dear Ms. Roesch-Miranowski:

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 January 21, 2014, the above facility is certified for:

38 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 38 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,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 6, 2014

Ms. Kathleen Roesch-Miranowski, Administrator
Sunrise Manor Nursing Home
240 Willow Street
Tyler, Minnesota 56178

RE: Project Number S5357023

Dear Ms. Roesch-Miranowski:

On December 27, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 12, 2013. 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 January 30, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 3, 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 December 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 21, 2014 . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 12, 2013, effective January 21, 2014 and therefore remedies outlined in our letter to you dated December 27, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245357	A. Building B. Wing	1/30/2014

Name of Facility	Street Address, City, State, Zip Code
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **01/12/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **01/12/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/17/2014**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **01/12/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KJ	2/6/2014	28651	1/30/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/12/2013			

AH Form Approved
2/6/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00338	A. Building B. Wing	1/30/2014

Name of Facility	Street Address, City, State, Zip Code
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	**01/17/2014**	ID Prefix **21520** Reg. # **MN Rule 4658.1300 Subp. 1-4** LSC	**01/12/2014**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	**01/12/2014**
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	

Reviewed By State Agency	**Reviewed By** KS/KJ	**Date:** 2/6/2014	**Signature of Surveyor:** 28651	**Date:** 1/30/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 12/12/2013		**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

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
245357	01 - TYLER HEALTHCARE CENTER	2/3/2014

Name of Facility	Street Address, City, State, Zip Code
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

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 K0062	Correction Completed 01/21/2014	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/KJ	2/6/2014	22373	2/3/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 12/16/2013			**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 — ID: 6FSW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00338

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245357**

2.STATE VENDOR OR MEDICAID NO.
(L2) **599245100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNRISE MANOR NURSING HOME**
(L4) **240 WILLOW STREET**
(L5) **TYLER, MN** (L6) **56178**

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 **12/12/2013** (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)
02/28

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

12.Total Facility Beds **38** (L18)

13.Total Certified Beds **38** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	38			
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Connie Brady, HFE NE II — 01/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/27/2014 (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
05/01/1986
(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

CCN-245357

On December 9 to December 12, 2013 the Departments of Health and Public Safety completed a CAH recertification survey and swing bed survey at Sunrise Manor. The survey team found standard level health and LSC deficiencies. Please refer to the CMS-2567 for survey results and the Providers Plan of Correction (PoC). Health Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7432

December 27, 2013

Ms. Kathleen Roesch-Miranowski, Administrator
Sunrise Manor Nursing Home
240 Willow Street
Tyler, Minnesota 56178

RE: Project Number S5357023

Dear Ms. Roesch-Miranowski:

On December 12, 2013, 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:

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Division of Compliance Monitoring
Licensing and Certification Section
1400 E. Lyon St.
Marshall, MN 56258
Telephone: (507) 537-7158 Fax: (507) 537-7194

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 January 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 March 12, 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 June 12, 2014 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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	The preparation of the following plan of correction for this licensing visit does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in this statement of deficiencies. This plan of correction is prepared solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to the following:	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	approved KMS 1/10/14	

RECEIVED
JAN 07 2014
Minnesota Department of Health
Marshall

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

Katie Rasmussen-Nugent — Administrator — 1/6/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an incident of alleged neglect immediately to the administrator and to the State agency (SA) for 1 of 2 residents (R35) reviewed for potential abuse/neglect. Findings include: R35 was admitted to the facility on 3/7/13 with diagnoses including: Alzheimer's disease, congestive heart failure, and neurogenic bladder. A quarterly minimum data set assessment indicated R35 was totally dependent on staff with bed mobility, locomotion (walking) on and off the unit, dressing and personal hygiene, and required extensive assistance of 2 with transfers. The brief interview for mental status (BIMS) had not been completed due to R35's difficulties with communication. Review of the facility's incident reports revealed an incident dated 6/15/13 at 2345 (11:45 p.m.) involving R35. The incident description indicated:	F 225	It is the policy and practice at Tyler Healthcare Center – Sunrise Manor that alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator and/or in the absence of the Administrator, to the person-in-charge designated through the facility policy, *Administrative Authority in Absence of the Administrator*. As of 12/18/2013, the DON, the Social Worker and the Administrator have reviewed the Conditions of Participation for F225 and F226 as well as the facility Abuse Prevention Plan and Abuse Reporting policy. The facility Abuse Prevention Team met on 12/30/13 for a scheduled annual review of the facility plan and policies. The DON, the Social Worker and the Administrator are members of this team and participated in the review, discussions and updates. The Sunrise Manor leadership team met on 1/2/14 and abuse prevention and reporting re-education was provided by the Administrator. The DON and nursing Case Managers will provide staff re-education on abuse prevention and reporting, including situations of potential neglect, by 1/12/14.	**Jan. 12, 2014**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 225	Continued From page 2 "Resident was found sitting on floor by bed with his legs to the side. He was facing towards HOB (head of bed) and his head was caught between the grab bar and mattresss [sic]. Immediately assisted away from grab bar/mattress and leaned against bed. Skin appeared dusky and a large deep red mark along right side of neck." The injury description indicated: "Skin appeared dusky initially but returned to normal color within a minute. Respirations non-labored. Deep red mark along right side of neck." The action taken was documented as: "Sent to "ER (Emergency Room) to be evaluated. Grab bar removed from bed. Will use U-shaped pillow and TABs (a brand of alarm) monitor when in bed. DON (director of nursing) was informed of incident and interventions." Review of a facility Physician Communication form dated 6/16/13, indicated the physician had responded to report of the above incident: "dx (diagnosis) status post fall. Head to toe assessment noted abrasions on Rt (right) lat (lateral) neck, skin tear on Rt ear, knee abrasion no change in mentation according to wife. Normal cares of abrasion injuries." During interview on 12/11/13 at 4:23 p.m., the DON confirmed that the facility had not reported this incident to the administrator immediately, nor had they reported to the SA. The DON stated they had not reported to the SA because there had been no injury, and because they felt they'd fixed the problem right away. The DON stated they had removed the grab bar from the resident's bed, the plan of care had been followed, and had decided the issue was an isolated incident. The DON stated the administrator had been notified the following	F 225	The Administrator, Social Worker and DON will review facility incident reports weekly for six weeks and then monthly for six months to assure that alleged violations involving mistreatment, neglect, or abuse have been reported immediately to the Administrator and/or person designated in the absence of the Administrator through facility policy and to the State Agency, providing additional staff education if necessary. Results of the reviews will be shared with the CQI Committee to determine effectiveness and/or the need for any further follow-up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 225	Continued From page 3 morning 6/16/13, at approximately 8:00 a.m. when the DON arrived at the facility. The facility's Abuse Prevention Plan, revised September 2013, included: "In Long-Term Care or Hospital Swing Bed, all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policies to ensure that an allegation of neglect was immediately reported to the administrator and to the State agency (SA) for 1 of 2 residents (R35) reviewed for potential abuse/neglect. Findings include: The facility's Abuse Prevention Plan, revised September 2013, included: "In Long-Term Care or Hospital Swing Bed, all alleged violations involving mistreatment, neglect, or abuse,	F 226	Tyler Healthcare Center – Sunrise Manor has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. As of 12/18/2013, the DON, the Social Worker and the Administrator have reviewed the Conditions of Participation for F225 and F226 as well as the facility Abuse Prevention Plan and Abuse Reporting policy. The facility Abuse Prevention Team met on 12/30/13 for a scheduled annual review of the facility plan and policies. The DON, the Social Worker and the Administrator are members of this team and participated in the review, discussions and updates. The Sunrise Manor leadership team met on 1/2/14 with abuse prevention and reporting re-education provided by the Administrator. The DON and nursing Case Managers will provide staff re-education on facility policies on abuse prevention and reporting by 1/12/14.	Jan. 12, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 226	Continued From page 4 including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)." Review of the facility's incident reports revealed an incident dated 6/15/13 at 2345 (11:45 p.m.) involving R35. The incident description indicated: "Resident was found sitting on floor by bed with his legs to the side. He was facing towards HOB (head of bed) and his head was caught between the grab bar and mattresss [sic]. Immediately assisted away from grab bar/mattress and leaned against bed. Skin appeared dusky and a large deep red mark along right side of neck." The injury description indicated: "Skin appeared dusky initially but returned to normal color within a minute. Respirations non-labored. Deep red mark along right side of neck." The action taken was documented as: "Sent to "ER (Emergency Room) to be evaluated. Grab bar removed from bed. Will use U-shaped pillow and TABs (a brand of alarm) monitor when in bed. DON (director of nursing) was informed of incident and interventions." According to review of the incident report, this incident was not immediately reported to the administrator or the SA. During interview on 12/11/13 at 4:23 p.m., the DON confirmed that the facility had not reported this incident to the administrator immediately, nor had they reported to the SA. The DON stated they had not reported to the SA because there had been no injury, and because they felt they'd fixed the problem right away. The DON stated they had removed the grab bar from the resident's bed, followed the plan of care, and had	F 226	Three random resident records will be reviewed each week for the next six weeks and then monthly for six months to assure that any documentation from the preceding week indicating alleged violations involving mistreatment, neglect, or abuse has a corresponding facility incident report and that reporting requirements have been met according to facility policies and procedures. Results of the reviews will be shared with the CQI Committee to determine effectiveness and/or the need for any further follow-up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 226	Continued From page 5 decided the issue was an isolated incident. The DON stated the administrator had been notified the following morning 6/16/13, at approximately 8:00 a.m. when the DON had come in to the facility.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document, review the facility failed to assess and monitor frequent bruising for 1 of 1 resident (R33) reviewed who had bruising/skin issues. Findings include: During observation and interview on 12/10/13 at 2:26 p.m., R33 was identified as having a large bruise on the top aspect of the left shin. It was observed to be dark purple in color measuring approximately 6 centimeters (cm) in diameter. R33 was also observed to have scattered bruising in various stages of healing, light brown in color, on the top aspect of the ankle/shin area bilaterally. R33 indicated the bruising occurred when staff lifted her legs during transfers. R33 further stated the bruising had been there since approximately "the first of the year", and that staff	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 309	Continued From page 6 had been more careful now in how they transferred her. Review of the record indicated R33's diagnoses included Alzheimer's disease and peripheral vascular disease. The care plan dated 10/24/13 indicated: "Potential impaired skin integrity...scattered bruises-bruises easily..." Approaches included: "Be aware resident bruises very easily by her own admission," and "Staff provide: observation of skin with all cares". Review of a nursing form, Shower Day Worksheet/Body Audit dated 12/11/13, identified R33 as having an "old bruise" on the front aspect of the right lower leg. The form was signed by nursing assistant (NA)-B and registered nurse (RN)-A. The bruise to R33's left shin observed on the previous day, 12/10/13 was not identified on this form. During interview on 12/12/13 at 12:04 p.m., the director of nursing (DON) confirmed that R33 bruised easily and stated that R33 had been offered, and refused to utilize, Dermasavers (pressure relieving skin protectors) to aid in protecting her legs from bruising. The DON stated that R33 utilized a foot stool in her room and would tend to pull it back towards herself by using her feet/legs while remaining seated in the chair. The DON stated that staff felt this had been the cause of some of the bruising to her legs. The DON also verified she was unaware of the dark purple bruise to R33's left lower leg. During observation and interview on 12/12/13 at 12:10 p.m., R33 was observed seated in her chair with both feet on the foot stool. The DON, present at that time, confirmed that R33 had what appeared to be a "fresh" bruise on her left lower	F 309	It is the practice at Tyler Healthcare Center – Sunrise Manor that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Charge nurse observed, investigated, and measured the bruise to R33's left shin and an incident report was generated on 12/12/2013 at 1500. A copy of the incident report was faxed to the MDH License and Certification Section on 12/13/2013 at 1440. Complete body skin checks were completed on all current residents by 12/23/2013 with incident reports, investigations, and monitoring generated if indicated. Memo to all staff on 12/12/2013 regarding reporting any new bruises to the Charge Nurse immediately for proper follow-up. Additional guidance was also provided to Charge Nurses on 12/16/2013. An Incident Report Log was implemented on 12/16/2013 to assist the staff in identifying when a bruise has previously been reported. *Skin Alteration* policy has been developed and staff will be educated on the policy by 1/17/2014. Bath aides are to complete weekly skin observations and Charge Nurses are to sign off on them. Skin alterations will be discussed at weekly IDT. A full body check will be done by a Charge Nurse weekly on residents that have been identified by IDT as being at high risk for bruising. The body check findings will be compared against recent incident reports to assure compliance with reporting. Results of these reviews will be shared with CQI Committee for any further recommendation.	**Jan. 17, 2014**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 309	Continued From page 7	F 309		

leg and stated that it could have actually happened that morning. The surveyor informed the DON that it had been observed and noted 2 days prior, on 12/10/13. The DON stated that due to the size of the bruise, it would be the expectation that staff report the bruise to the nurse, further indicating that it may have already been reported.

During interview on 12/12/13 at 12:20 p.m., NA-A stated that upon discovery of a new bruise or skin issue, she would report this immediately to the nurse. NA-A confirmed she had assisted R33 with morning cares. NA-A further stated the bruise on R33's left leg "has been there for a while" and therefore had not reported it to the nurse.

Later, during an interview on 12/12/13 at 1:02 p.m., the DON confirmed the bruising to R33's left lower leg had not been reported. The DON stated that the "old bruising" to R33's lower legs had been documented on the bath audit sheets and indicated the NA's may not know whether R33's bruising was new or not due to the ongoing bruises noted on the lower legs.

During interview on 12/12/13 at 1:22 p.m., the DON confirmed that upon discovery and identification of a bruise or skin issue, the charge nurse is notified, who would assess and measure the bruise, complete an incident report, and if unable to determine the cause would notify the administrator and then file a vulnerable adult (VA) report. Subsequently, the bruise is monitored and documented in the treatment book. The DON stated the care plan indicated that R33 had chronic bruising to the lower legs and further reported the measurement of R33's bruise noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 309	Continued From page 8 on the left shin was 6.4 cm by 3.9 cm.	F 309		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer medications via gastrostomy tube (G-tube) per facility policy for 1 of 1 resident (R21) who were observed for medication administration via G-tube. Findings include: During medication administration on 12/11/13 at	F 425	It is the practice at Tyler Healthcare Center – Sunrise Manor that medications are administered as per facility policy. A physician's order was received by R21's primary physician on 12/12/2013 at 1400 to mix medications into one administration and flush as needed due to increased residuals. Facility policy "*Medication Installation through an Enteral Feeding Tube*" was made available for Charge Nurses to review on 12/16/2013. Pharmacy consultant was also notified on 12/16/2013 with no further recommendations. A review was done on G-tube feeding and found to be in compliance with facility policy. Physician also being contacted regarding the need for any special medication administration guidelines for the other resident with G-tube feedings. Two random G-tube medication administration reviews will be completed by nursing each week and once monthly by pharmacy consultant for two months and then once monthly by nursing and pharmacy consultant for four months. Results of the reviews will be shared with CQI Committee for any further recommendations.	**Jan. 17, 2014**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 425	Continued From page 9 9:59 a.m., registered nurse (RN)-A was observed setting up R21's medications to be administered via his G-tube. RN-A set up R21's liquid medications (multi vitamin, Lasix, potassium chloride, prednisolone, calcium carbonate, and vitamin D) into separate medication cups. Medications R21 was to receive in tablet form (aspirin, xenazine, and levothyroxine) were each placed into the same medication cup. RN-A then was observed to transfer the tablet form medications (aspirin, xenazine, and levothyroxine) into a plastic sleeve, crushed them all together, then poured the crushed medications back into the medication cup and mixed together with approximately 30 centimeters (cc's) of water (H2O). R33 was also scheduled to receive a powdered protein supplement which RN-A was observed to mix with approximately 90 cc's of H2O into a cup. RN-A was observed to administer a small amount of the protein supplement mixed with H2O into R21's G-tube. RN-A explained that she would utilize the remainder of the protein/H2O mix between the medications as "it's mostly water anyway". RN-A proceeded to administer R21's medication but only flushed with the Protein/H2O mixture following administration of every 2 medications administered. RN-A was also observed to administer the crushed levothyroxine, xenazine, and aspirin that were mixed together with H2O to R21 via the G-tube. Upon finishing the medication administration, RN-A proceeded to administer the resident's Jevity feeding and followed the feeding by flushing the G-tube with 50 cc's of H2O. RN-A confirmed that she did not flush the G-tube between each separate medication as the resident was on a fluid restriction and she didn't	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 425	Continued From page 10 want to give R21 too much water. RN-A further confirmed that she crushed and administered R21's aspirin, xenadine, and levothyroxine together and did not think there was a physician's order to do so. During interview on 12/12/13 at 11:49 a.m., the director of nursing (DON) stated that because R21 was on a fluid restriction she would not expect nurses to flush the G-tube between each medication administered. The DON stated that nursing has had conversations with the physician about this and the physician had approved not flushing between each medication though the record did not include a physician order nor documentation to support this. The DON further acknowledged being aware that R21's oral tablet medications were being crushed and administered together, and stated she did not believe there was a physician's order to do so. The facility policy/procedure titled, Medication Installation Through an Enteral Feeding Tube, dated 12/2013, indicated: "...Tablet: Crush tablet to a fine powder and dissolve in 30 cc warm water. If there is more than one tablet, crush and dilute each one individually...When administering more than one medication, give each separately, and flush between each with 15 to 30 ml (milliliters) of warm water. If patient is on a fluid restriction, limit flushes between medications to 5 to 10 ml of warm water. Adjust the amount of free water to reflect the amount of water that was given for medications."	F 425		

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

F5357022

PRINTED: 12/27/2013
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
	245357	A. BUILDING 01 - TYLER HEALTHCARE CENTER B. WING _____	12/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 16, 2013. At the time of this survey, Tyler Health Care Center - Sunrise Nursing Home was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	The preparation of the following plan of correction for this licensing visit does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in this statement of deficiencies. This plan of correction is prepared solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to the following; POC ok PB 1-8-14 RECEIVED JAN - 6 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 1-31-14

EXIT: 12-12-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	1/6/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING 01 - TYLER HEALTHCARE CENTER B. WING _____	12/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 1	K 000		

By eMail 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.

Note: Because the existing one-story nursing home is not separated from the attached existing one-story critical access hospital [CAH] by a complying 2-hour fire wall assembly, the CAH was surveyed as a part of the nursing home, and one (1) CMS Form 2786R booklet was completed.

Tyler Health Care Center - Sunrise Nursing Home was constructed as follows:
The original building was constructed in 1957, is one-story, has a partial basement, is fully sprinklered and was determined to be of Type II (111) construction;
In 1976 the basement shell space Addition was constructed. This addition is fully sprinklered and was determined to be of Type V(111) construction.
Tyler Healthcare Center [critical access hospital] was constructed in 1957, is one-story, has a partial basement, is fully sprinklered and was determined to be of Type II (111) construction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING 01 - TYLER HEALTHCARE CENTER B. WING _____	12/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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 The facility has smoke detection at smoke barrier doors and in spaces open to the corridor, which are monitored for automatic fire department notification. The facility has a capacity of 38 beds and had a census of 38 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire sprinkler system in accordance with the provisions at NFPA 101 (2000) Chapter 19, Section 19.3.5 and NFPA 25 (1998). In a fire emergency, this deficient practice could adversely affect 38 of 38 residents, staff and visitors. FINDINGS INCLUDE: On 12/16/2013 at 12:05 PM, while surveying in the nursing home Boiler Room, observation revealed a corroded fire sprinkler. This arrangement was not in conformance with the requirements at NFPA 25, (1998) Chapter 2, Section 2-2.1.1. This finding was verified with the facility's chief building engineer.	K 062	The corroded fire sprinkler in the nursing home boiler room will be replaced on January 21, 2014 by Building Sprinkler. The Environmental Services Manager will monitor ongoing compliance and will educate the maintenance staff on the requirement by January 8, 2014. The Environmental Services Manager is the person responsible to assure compliance.	Jan. 21, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING 01 - TYLER HEALTHCARE CENTER B. WING _____	12/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING HOME	240 WILLOW STREET TYLER, MN 56178

(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7432

December 27, 2013

Ms. Kathleen Roesch-Miranowski, Administrator
Sunrise Manor Nursing Home
240 Willow Street
Tyler, MN 56178

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5357023

Dear Ms. Roesch-Miranowski:

The above facility was surveyed on December 9, 2013 through December 12, 2013 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1400 E Lyon St Marshall, Mn 56258-2529. 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 Kathy Serie at (507) 537-7158 .

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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File