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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 7WO6
Facility ID: 00048

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245045**
2. STATE VENDOR OR MEDICAID NO. (L2) **695045102**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE HEALTH CARE CENTER**
(L4) **512 SKYLINE BOULEVARD**
(L5) **CLOQUET, MN** (L6) **55720**

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 **05/30/2014** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

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

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

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12. Total Facility Beds **44** (L18)
13. Total Certified Beds **44** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 06/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 07/02/2014 (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 **01/01/1967** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

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

25. LTC EXTENSION DATE: (L27)

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/28/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5045

June 10, 2014

Mr. Cory Glad, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

Dear Mr. Glad:

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 May 20, 2014 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 10, 2014

Mr. Cory Glad, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, MN 55720

RE: Project Number S5045024

Dear Mr. Glad:

On April 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 10, 2014. 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 May 30, 2014, 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 April 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 10, 2014, effective May 20, 2014 and therefore remedies outlined in our letter to you dated April 24, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245045	A. Building B. Wing	5/30/2014

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**05/20/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**05/20/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**05/20/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**05/20/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**05/20/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**05/20/2014**
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	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	06/10/2014	12835	05/30/2014
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
4/10/2014				

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

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00048

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3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE HEALTH CARE CENTER**
(L4) **512 SKYLINE BOULEVARD**
(L5) **CLOQUET, MN** (L6) **55720**

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 **04/10/2014** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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From (a) :
To (b) :

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

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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
	44			
(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 :
Cheryl Johnston, HFE NEII 05/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/27/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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01/01/1967
(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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5045

On April 10, 2014, a standard survey was completed. Deficiencies were found. The facility is given an opportunity to correect before remedies would be imposed. Post Certification Revisit (PCR). Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #7011 2000 0002 5143 7333

April 24, 2014

Mr. Cory Glad, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

RE: Project Number S5045024, H5045009

Dear Mr. Glad:

On April 10, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the April 10, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5045009. 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. In addition, at the time of the April 10, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5045009 that was found to be unsubstantiated.

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>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not**

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

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

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

DEPARTMENT CONTACT

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

Pat Halverson, Unit Supervisor
Division of Compliance Monitoring
Licensing and Certification Program
Duluth Technology Building
11 East Superior St., #290
Duluth, MN 55802

Phone (218) 302 6151
Fax (218) 723 2359

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 May 20, 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 July 10, 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 October 10, 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 related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5045s14.rtf

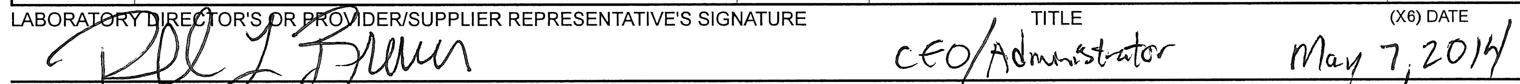
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING ______ B. WING ______	04/10/2014

RECEIVED
MAY 08 2014
MN Dept of Health

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	**512 SKYLINE BOULEVARD** **CLOQUET, MN 55720**

(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 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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS: 41 A recertification survey was conducted and a complaint investigation was also completed at the time of the standard survey. Investigation of complaint H5045009, was completed. The complaint related to H5045009, was not substantiated.	F 000	***These plans and responses to these survey findings are written to solely maintain certification in the Medicare and Medical Assistance Programs and as required are submitted as CREDIBLE ALLEGATION OF COMPLIANCE.*** ***This written response does not constitute an admission of noncompliance with any requirement.*** OK 5-9-14 PLH	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO/Administrator — (X6) DATE: May 7, 2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING ______ B. WING ______	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

(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 164	Continued From page 1 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did provide privacy during blood glucose monitoring for 2 of 3 residents (R16, R39) whose Accuchecks were observed. Findings include: On 4/7/14, at 4:01 p.m. licensed practical nurse (LPN)-A approached R16 while she was sitting in the day room at a table with three other residents and another resident at a table near by. The LPN stated to R16, "Can I bug you for a minute?" The LPN applied gloves, cleaned R16's finger with an alcohol wipe, poked R16's finger, obtained the blood sample, wiped R16's finger with a cotton ball then removed her gloves. On 4/7/14, at 4:16 p.m. LPN-A entered R39's room with the roommate present in the room. The	F 164	*SHCC does provide personal privacy and confidentiality of his/her personal and clinical records for all residents. This deficiency was noted on only 2 of 41 residents.* *R16 was corrected by informing and coaching LPN-A regarding resident's privacy during blood glucose monitoring.* *R39 was corrected by informing and coaching LPN-A regarding privacy during blood monitoring. R39's roommate is legally blind and in unable to see that far; therefore, R39's privacy was provided.* *Measures to correct the deficient practice are as follows: All nursing staff will be educated on proper policy and procedure regarding providing resident's privacy during blood glucose monitoring.* *Monitoring will be done by a QA tool watching staff performance. This will be done by an RN weekly for 2 months. If in compliance, monitoring will be done monthly for 1 month, and then to random audits.* *The DON will be responsible.* *Results will be provided to the quarterly LTC QA committee meeting.* *The Privacy Policy was updated and revised.*	*5/20/14*

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	245045	A. BUILDING ______ B. WING ______	04/10/2014

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F 164	Continued From page 2 LPN applied gloves, set up the blood glucose machine and supplies, cleaned R39's finger with an alcohol wipe, poked R39's finger, obtained the blood sample, wiped R39's finger with a cotton ball then removed her gloves. The LPN did not pull the privacy curtain between the two residents or ask the resident or the roommate's permission to do the blood glucose check in each other's presence. On 4/7/14, at 6:45 p.m. during an interview, LPN-A stated she usually takes residents to a private area but R16, "Can get a little feisty". LPN-A stated she should have pulled the curtain between the R39 and her roommate. The director of nursing (DON), interviewed on 4/9/14, 10:15 a.m., stated blood glucose monitoring should not be done in the day room and residents should be provided privacy. The DON stated some residents were resistive to leaving the day room to have their blood sugars checked. "In the resident's room if the roommate had a problem with it then yes the curtain should be pulled." A policy regarding providing residents privacy during blood glucose monitoring was requested but was not provided.	F 164		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242		

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F 242	Continued From page 3 are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident choice for frequency of bathing was consistently honored for 3 of 4 residents (R36, R42, R37) reviewed for choices. Findings include: R36 was not consistently provided a shower twice a week based on his bathing preferences. On 4/7/14, at 3:22 p.m. R36 stated he didn't always get his shower twice a week as he preferred, "I guess they were too busy. I prefer two." A Resident Note dated 8/21/13, indicated R36 would prefer two showers per week. The quarterly Minimum Data set (MDS) dated 2/12/14, indicated R36's diagnoses included Parkinson's disease and congestive heart failure (CHF). The MDS identified R36 had moderate cognitive impairment with no behaviors; required the physical help of one staff with bathing; and had functional limitations in range of motion (ROM) in one upper extremity. The self care (dress, personal hygiene, bathing) care plan reviewed 2/28/14, indicated R36 required assistance with all activities of daily living (ADL's); preferred two showers per week; and required the extensive assistance of one staff to transfer to the shower chair with hands on assist as needed. The nursing assistant care sheets	F 242	***All of our residents do have the right to make choices.*** ***SHCC does honor resident bathing preferences. The deficiency was noted on only 3 out of 41 residents.*** ***Any resident who is able to make choices will be asked by the RN on admission what their bathing preference is and how often they would prefer to have it. If a resident is unable to make choices, a family member will be asked. This will be reviewed at each care conference by the Nurse Manager to ensure resident's preferences are being honored. RN's will be in-serviced and documentation will be added to the Nursing Admission Assessment, and it will be included in the care conference notes.*** ***CNA's will be in-serviced on the policy and procedure regarding "Refusal of Care". This protocol has been added to the Care Tracker (electronic care charting system) under bathing to alert staff of the steps needed for refusal. CNA's will document that they have notified the RN Supervisor in the "text" part of Care Tracker. RN's will follow-up and document.***	*5/20/14*

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F 242	Continued From page 4 (not dated) directed R36 was to receive a bath on Wednesday and Sunday mornings. The Bath Schedule and Weights list (not dated), also indicated R36 was scheduled for a bath/shower on Wednesday and Sunday. Review of the Resident Bathing documentation from the compute indicated R36 did not receive a Sunday shower on 1/12/14, 1/26/14, 2/9/14, 2/23/14, 3/2/14, and 3/9/14. On 4/9/14, at 9:44 a.m. the registered nurse manager (RN)-A verified the inconsistent shower record. On 4/9/14, at approximately 9:55 a.m. RN-A stated nursing assistant (NA)-A was working on the Sundays when R36 did not have a shower. NA-A told RN-A that R36 refused his shower on those days. RN-A confirmed there was no documentation regarding the refusals or possible interventions attempted. On 4/10/14, at 9:00 a.m. R36 was questioned regarding possible refusals of showers offered. R36 stated, "No, I wouldn't because I like my showers." R42 had not received a bath or a shower since admission on 3/15/14. On 4/7/14, at 4:19 p.m. R42 stated she had not had a shower or a bath since she came to the facility. "They don't ask how often I would like one. I would prefer to take a shower twice a week. I will be going home soon. If I had a shower I would like it earlier in the day not at 9:00 or 10:00 at night. They offered once but it was too late." The Cumulative Diagnosis List dated 3/18/14,	F 242	***Audits will be conducted weekly for R36 and R37 for one month, then every other week for 1 month and then monthly for one month. If there is a problem noted, we will extend the audit for another month. R42 has been discharged home. We will randomly audit other residents who have requested more than 1 shower/bath per week.*** ***Results from the quarterly audits will be brought to the LTC QA/QI meeting by the DON for review and recommendations.***	

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F 242	Continued From page 5 indicated R42's diagnoses included chronic obstructive pulmonary disease, osteoarthritis, osteoporosis, hard of hearing and chronic right shoulder dislocation. The admission MDS dated 3/25/14, identified R42 had no cognitive impairment. R42 transferred with the extensive assistance of two staff, needed extensive assistance of one staff with dressing and physical help of one staff with bathing. R42 had no rejection of care and it was very important to her to choose between a tub bath, shower or bed bath. The Bath Schedule and Weights list (not dated) indicated R42's bath/shower was scheduled on Wednesday evenings. Review of the Resident Bathing Type by Day Chart from 3/10/14 to 4/8/14, indicated R42 had a bed bath on 3/19/14. On 4/1/14, 4/3/14, 4/7/14 and 4/8/14 R42's bath type was recorded as, "Other." During an interview with the occupational therapist (OT) on 4/9/14, at 9:15 a.m., the OT stated "other" indicated R42 washed up at the sink with OT. The Care Tracker (electronic care charting system) Observation Edit for shower/bath choice dated 3/26/14, at 11:00 p.m. was documented by NA-F and indicated R42 refused a bath/shower. On 4/9/14, at 8:50 a.m. the health unit coordinator (HUC) stated the bath schedule is set up according to room number but was not set in stone, was in constant motion and changed according to resident preference/request or their beauty shop times	F 242		

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F 242	Continued From page 6 On 4/9/14, at 8:58 a.m. R42, stated she did refuse the shower, she did not want it late at night because it wakes her up. R42 had not told anyone she did not want her shower late at night. R42 took a shower at home twice a week. On 4/9/14, at 3:30 p.m. NA-F stated on 3/26/14, R42 did not receive her shower because it was too late. NA-F did not remember if she had told anyone but should have reported it. On 4/9/14, at 3:25 p.m. RN-A stated she interviewed RN-C who was on duty the evening of 4/2/14. RN-C stated NA-F reported to him that R42 refused her shower in the evening of 4/2/14. RN-A was unaware R42 did not want her shower at night or that R42 had not had a shower since admission. The facility's Resident Choice of Bathing Options policy, reviewed on 1/1/14, indicated bathing choices will be discussed upon admission, with significant changes and yearly. Bathing choices would be discussed at the resident's quarterly care conference to ensure the resident is receiving individualized and preferred bathing choices. The preferences would be communicated to the RN or HUC. The established plan if a resident refused a bath or shower, the NA would re-approach, if the resident continued to refuse the NA was directed to utilize the assistance of their hall partner in approaching the resident. If all attempts are futile the RN supervisor was to be notified. R37 was not receiving the requested number of baths per week. During an initial resident interview on 4/8/14, at 1:36 p.m. R37 stated only one bath per week was	F 242		

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F 242	Continued From page 7 being provided. R37 further stated he was unsure what had happened to decrease the bathing frequency or when the bathing schedule was changed. A Cumulative Diagnosis List dated 11/16/09, indicated R37's diagnoses included diabetes mellitus type 2 and degenerative joint disease. A quarterly MDS dated 2/6/14, indicated R37 had moderate cognitive impairment with a BIMS [Brief Interview for Mental Status] score of 12. The MDS further indicated R37 required extensive assistance with personal hygiene activities and required physical help in part of bathing activity. An electronic Recreational Therapy Note dated 8/26/13, indicated R37 preferred a bath three times per week and was currently receiving a bath twice weekly with nursing staff aware. Another electronic Recreational Therapy Note dated 11/18/13, indicated an MDS review was completed and R37 preferred a bath once a week. R37's Plan of Care dated 11/14/13, indicated R37 required extensive assistance of one staff with bathing and would occasionally refuse personal hygiene. Review of the Bath Schedule for R37's unit [undated] indicated R37 was to receive a bath on Mondays. A Nursing Assistant Assignment Sheet [undated] indicated R37 was to receive a bath on Monday morning and if R37 refused care, the Assignment Sheet directed staff to leave and re-approach.	F 242		

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F 242	Continued From page 8 Review of a computer-generated Bath Type Detail Report dated 4/10/14, indicated R37 had received a shower only 5 times from 2/11/14, to 4/7/14. A computer-generated Resident Bathing Type by Day Chart dated 4/10/14, indicated R37 was not provided a weekly bath on 5 separate occasions. On 4/10/14, at 3:02 p.m. RN-B stated R37 had a history of refusing cares. RN-B further stated nursing assistant staff were directed to re-approach R37 when bathing refusal occurred, and if R37 continued to refuse, alert the nursing staff. RN-B further stated nursing staff were then to work with R37 about the refusals and document the outcome in the nursing progress notes in R37's electronic medical record. RN-B stated she could not recall if R37 had ever requested to have more than one bath per week. RN-B confirmed R37's medical record lacked documentation R37 had been refusing baths.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide bathing as directed by the care plan for 1 of 4 residents (R36) reviewed for choices. Findings include:	F 282	***SHCC provides or arranges services in accordance with each resident's written plan of care. This deficiency was found on only one of the 41 residents.*** ***R36 was corrected by talking to the aide regarding refusal of showers. Care plan is accurate with resident's bathing preference.***	***5/20/14***

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F 282	Continued From page 9 On 4/7/14, at 3:22 p.m. R36 stated he was supposed to get a shower twice a week, but didn't always get the second one, "I guess they were too busy." The quarterly Minimum Data set (MDS) dated 2/12/14, indicated R36's diagnoses included Parkinson's disease, congestive heart failure (CHF), and identified R36 had moderate cognitive impairment with no behaviors. The self care (dress, personal hygiene, bathing) care plan reviewed 2/28/14, indicated R36 required assistance with all activities of daily living (ADL's); preferred two showers per week; and required the extensive assistance of one staff to transfer to the shower chair with hands on assist as needed. The nursing assistant care sheets (not dated) directed R36 was to receive a bath on Wednesday and Sunday mornings. Review of the Resident Bathing documentation from the computer indicated R36 did not receive a second Sunday shower on 1/12/14, 1/26/14, 2/9/14, 2/23/14, 3/2/14, and 3/9/14. On 4/9/14, at 9:44 a.m. the registered nurse manager (RN)-A verified R36 was not provided twice weekly showers as directed by the care plan.	F 282	*Measures to correct the deficient practice are as follows: All staff will be educated on proper procedures for refusal of care and following plan of care; Nurse managers will review at the care conference quarterly; Update care plan if preference changes; and CNA's will be in-serviced on the policy and procedure regarding "Refusal of Care". This protocol has been added to the Care Tracker (electronic care charting system) under bathing to alert staff of the steps needed for refusal. CNA's will document that they have notified the RN Supervisor in the "text" part of Care Tracker. RN's will follow-up and document.* *Monitoring will be done weekly for 1 month, then monthly for 3 months concerning resident refusals and preference, and if staff is following resident preference. The correction will be monitored by the DON to ensure compliance.* *Monthly- Issues will be brought to the Resident Care Team meeting with results of audits by the DON.* *Quarterly- Results of audits will be brought to the LTC QA/QI meeting by the DON for review and recommendations.*	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356		

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F 356	Continued From page 10 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post, on a daily basis, the actual hours worked for both licensed and unlicensed staff. This had the potential to affect all 41 residents currently residing in the facility and the visitors. Findings include: The staff posting was observed incorrectly posted on 4/7/14, at 1:00 p.m. and 4/8/14, at 10:00 a.m.	F 356	*SHCC does post Nurse Staffing information on a daily basis. In most cases, the actual hours worked were greater than hours posted.* *Measures put into place are as follows: The total number and the actual hours worked will be posted daily at the beginning of each shift; The facility will maintain staffing data for a minimum of 18 months; All RN's and Staffing Coordinator will be educated on the information needed for the Nurse Staffing Post.* *Monitoring will be done weekly for one month, and then every other week for one month and then monthly for one month to assure the Nurses Post is corrected. The correction will be monitored by the DON to ensure compliance.* *Monthly-Issues will be brought to the Resident Care Team meeting with results of audits by the DON.* *Quarterly-Results of the audits will be brought to the LTC QA/QI meeting by the DON for review and recommendations.*	*5/20/14*

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F 356	Continued From page 11 During initial tour of the facility on 4/7/14, at approximately 1:00 p.m. the daily staff posting was observed on an end table by the second floor elevator. The posting lacked identification of the actual shift hours worked by each category of nursing staff directly responsible for resident care. Under the column for Hours Worked RN & LPN's, the facility entered the shift hours. The posting indicated that on Monday 4/7/14, day shift, one registered nurses worked 6:30 - 3:00, one licensed practical nurse worked 6:30 - 3:00, one licensed practical nurse worked 6:00 - 12:30, and six nursing assistants from 6:00 - 2:30. Review of the staff posting for the month of March, 2014, indicated that all 24 postings provided lacked documented total hours worked for each of the staff. The Director of Nursing stated on 4/10/14, at 2:00 p.m. the facility's policy was to post the nurse staffing daily. A policy on staff posting was requested but not provided.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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

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F 441	Continued From page 12 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure proper hand hygiene prior to insulin administration for 1 of 1 residents (R24) observed for infection control practices. Findings include:	F 441	*SHCC provides a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.* *LPN-A has been coached and educated on proper hand hygiene.* *The LPN Staff will be re-educated on the hand hygiene policy.* *Random audits will be conducted for one month. The correction will be monitored by the DON or designee.* *Monitoring will be done by a QA tool watching staff performance. This will be done by an RN weekly for 2 months. If in compliance, monitoring will be done monthly for 1 month, and then to random audits.* *Monthly-Issues will be brought to the Resident Care Team meeting with results of audits by the DON.* *Quarterly-Results of audits will be brought to the LTC QA/QI meeting by the DON for review and recommendations.*	*5/20/14*

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING ______ B. WING ______	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

(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 441	Continued From page 13 On 4/7/14, at 4:16 p.m. licensed practical nurse (LPN)-A was observed to complete blood glucose monitoring for R39. LPN-A completed the procedure, removed the gloves, sanitized the hands, donned new gloves and cleaned the blood glucose machine. LPN-A removed the gloves but did not wash or sanitize the hands. LPN-A returned to the medication cart and drew up R24's insulin, brought R24 to her room, put on new gloves and administered the insulin. LPN-A, interviewed at 6:45 p.m., stated she did not know she failed to sanitized her hands between the blood glucose monitor and drawing up and administering insulin. On 4/10/13, at 9:35 a.m., the infection control registered nurse (RN)-D, stated it was the facility's policy to sanitize or wash hands between glove changes and between residents. The facility's Hand Hygiene policy reviewed and revised on 8/28/14, indicated hand hygiene should be done before and after resident contact, before and after removing any type of gloves used in resident care and after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 465		

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

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	245045	A. BUILDING ______ B. WING ______	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 14 Based on observation and interview the facility failed to ensure that 17 of 41 resident rooms (R1, R14, R15, R17, R20, R21, R26, R28, R36, R37, R39, R42, R50, R54, R55, R60 and R61) were maintained and repaired related to walls, flooring, ceilings, bedroom and bathroom fixtures. Findings include; During the environmental tour with the Director of Building and Grounds (DBG) on 4/10/14, at 1:38 p.m., the following was noted: Bedroom and/or bathroom doors were noted to be scraped, scarred or chipped, exposing rough edges for R15, R20, R36, R42 and R61. The bathroom plumbing was covered with gray foam taped to the plumbing fixtures in the bathroom for R17 and R26. The taped on foam covering was not cleanable and unsightly. Bedroom and/or bathroom moldings were scraped, scarred or chipped with exposed rough edges for residents R21 and R39. The floor tile grout was stained dark gray to black in the bathrooms utilized by R1, R37, R50 and R60. Door handles were missing on the closet doors for R21 and R55. R54's bedroom had a ceiling tile with large water stain. The radiator covering in R37's room was bent, exposing a sharp edge.	F 465	*Room 252, Room 275 1 & 2, Room 274 1&2* *Bedroom and/or bathroom doors will be repaired.* *Room 264* *Padding was removed. Completed on 5/6/14.* *Room 272-2, Room 258-2* *Moldings will be repaired.* *Room 260, 250, 262* *Floor tile and grout will be cleaned.* *Room 272-2, Room 273-1* *Closet door handles were replaced. Completed on 5/6/14.* *Room 253-2* *Ceiling tile will be replaced.* *Room 250* *Radiator covering has been fixed. Completed on 5/6/14.* *Room 273 1&2* *Painting will be completed.* *Room 263-2, Room 272-2* *Walls will be repaired.* *A monthly maintenance audit will be developed.* *Director of Building & Grounds is the responsible person.*	*5/20/14*

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING ______ B. WING ______	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 15 Wall repairs were patched but not painted in the bedrooms for R14 and R55. R21 and R28 had numerous holes in the bathroom and bedroom walls. The DBG, interviewed on 4/10/14, at approximately 2:00 p.m. stated there was no preventative maintenance program for the facility. DBG stated he relied on the nursing or housekeeping staff to tell him when something needed repair or touch up. He stated the painting has fallen behind in the resident areas since the painters are working on the first floor where there are no residents.	F 465		

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

F5045021

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
	245045	A. BUILDING **01 - MAIN BUILDING** B. WING ______	04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	**512 SKYLINE BOULEVARD CLOQUET, MN 55720**

(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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Sunnyside Health Care Center was found 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. Sunnyside Care Center, is a 3-story building with no basement. The original building was constructed in 1962 and was determined to be of Type II(111) construction. In 1968 the second floor was added, aslo Type II(111) construction. In 2000 dining rooms were constructed on floors one and two of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. This skilled nursing home is not 2 hour fire rated separated from the attached hospital, and the hospital was also inspected. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 44 beds and had a census of 41 at the time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**04/09/2014**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		

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

F5045021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245045	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - DINING/ACTIVITY B. WING ______	(X3) DATE SURVEY COMPLETED 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

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K 000	INITIAL COMMENTS Building #2 "New" Nursing Home Dining Room Addition FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Communinty Memorial Hospital-Sunnyside NH (bldg. #2) was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 482.41(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. Community Memorial Hospital-Sunnyside NH,Building #2 (New Nursing Home)) is a 3 story building with a full basement, Type I (332) construction. The building was constructed in 2012/2013 and is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in corridors, spaces open to the corridors and sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 41 at the time of the survey. NOTE: The Community Memorial Hospital-Sunnyside NH and is not 2 hour fire separated. Therefore, this inspection is broken down into 2 distinctly different parts. i,.e, New Hospital, and New Nursing Home, Exist Hospital & Existing Nursing Home This is based on the different years of construction. The requirement at 42 CFR, Subpart 482.41(a) is met.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245045	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - DINING/ACTIVITY B. WING	(X3) DATE SURVEY COMPLETED 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7333

April 24, 2014

Mr. Cory Glad, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5045024, H5045009

Dear Mr. Glad:

The above facility was surveyed on April 7, 2014 through April 10, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5045009. that was found to be unsubstantiated. 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 <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 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, 11 East Superior Street #290, Duluth, Minnesota55802. 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 Patricia Halverson at (218) 302-6151.

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5045s14lic.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00048	A. BUILDING: ______ B. WING ______	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/7/14, through 4/10/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. A complaint investigation was completed at the time of the standard survey. The complaint H5045009 was not substantiated.	2 000	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	00048	A. BUILDING: ____ B. WING ____	04/10/2014

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2 000	Continued From page 1	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide bathing as directed by the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 2	2 565		

care plan for 1 of 4 residents (R36) reviewed for choices.

Findings include:

On 4/7/14, at 3:22 p.m. R36 stated he was supposed to get a shower twice a week, but didn't always get the second one, "I guess they were too busy."

The quarterly Minimum Data set (MDS) dated 2/12/14, indicated R36's diagnoses included Parkinson's disease, congestive heart failure (CHF), and identified R36 had moderate cognitive impairment with no behaviors.

The self care (dress, personal hygiene, bathing) care plan reviewed 2/28/14, indicated R36 required assistance with all activities of daily living (ADL's); preferred two showers per week; and required the extensive assistance of one staff to transfer to the shower chair with hands on assist as needed. The nursing assistant care sheets (not dated) directed R36 was to receive a bath on Wednesday and Sunday mornings.

Review of the Resident Bathing documentation from the computer indicated R36 did not receive a second Sunday shower on 1/12/14, 1/26/14, 2/9/14, 2/23/14, 3/2/14, and 3/9/14.

On 4/9/14, at 9:44 a.m. the registered nurse manager (RN)-A verified R36 was not provided twice weekly showers as directed by the care plan.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop a system to ensure resident care plans are followed by all staff, and could develop

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2 565	Continued From page 3 monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 565		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure proper hand hygiene prior to insulin administration for 1 of 1 residents (R24) observed for infection control practices. Findings include: On 4/7/14, at 4:16 p.m. licensed practical nurse (LPN)-A was observed to complete blood glucose monitoring for R39. LPN-A completed the procedure, removed the gloves, sanitized the hands, donned new gloves and cleaned the blood glucose machine. LPN-A removed the gloves but did not wash or sanitize the hands. LPN-A returned to the medication cart and drew up R24's insulin, brought R24 to her room, put on new gloves and administered the insulin. LPN-A, interviewed at 6:45 p.m., stated she did not know she failed to sanitized her hands between the	21385		

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SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

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21385	Continued From page 4 blood glucose monitor and drawing up and administering insulin. On 4/10/13, at 9:35 a.m., the infection control registered nurse (RN)-D, stated it was the facility's policy to sanitize or wash hands between glove changes and between residents. The facility's Hand Hygiene policy reviewed and revised on 8/28/14, indicated hand hygiene should be done before and after resident contact, before and after removing any type of gloves used in resident care and after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of	21426		

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	00048	A. BUILDING: ______ B. WING ______	04/10/2014

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Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the nursing home.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 3 of 5 residents (R10, R61, R21) received baseline screening for active tuberculin (TB) risk factors and symptoms according to the Centers for Disease Control (CDC) guidelines.

Findings include:

The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline TB screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms.

R10 was admitted to the facility on 1/28/14. R10's medical record lacked evidence an assessment for risk factors and a physical screening for active symptoms of TB had been completed.

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R61 was admitted to the facility on 3/19/14. R61's medical record lacked evidence an assessment for risk factors and a physical screening for active symptoms of TB had been completed.

R21 was admitted to the facility on 3/14/14. R21's medical record lacked evidence an assessment for risk factors and a physical screening for active symptoms of TB had been completed.

On 4/8/14, at 4:20 p.m. the director of nursing (DON) stated that, upon a resident's admission, the facility's computer program directed staff to complete the TB history and symptom screening. The DON verified the TB history and symptom screening had not been completed on admission for R10, R61, and R21.

The facility's Tuberculosis (TB) Infection Control Plan policy and procedure, reviewed and revised on 8/21/13, indicated residents would be assessed for current symptoms of active TB, TB risk factors and TB history.

SUGGESTED METHOD FOR CORRECTION:
The director of nursing (DON) or designee could review the current TB policies and procedures to ensure all residents are screened for history and physical signs and symptoms of active TB disease on admission.
The DON or designee could educate the appropriate staff on the policies/procedures, and could develop a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.

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21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure that 17 of 41 resident rooms (R1, R14, R15, R17, R20, R21, R26, R28, R36, R37, R39, R42, R50, R54, R55, R60 and R61) were maintained and repaired related to walls, flooring, ceilings, bedroom and bathroom fixtures. Findings include; During the environmental tour with the Director of Building and Grounds (DBG) on 4/10/14, at 1:38 p.m., the following was noted: Bedroom and/or bathroom doors were noted to be scraped, scarred or chipped, exposing rough edges for R15, R20, R36, R42 and R61. The bathroom plumbing was covered with gray foam taped to the plumbing fixtures in the bathroom for R17 and R26. The taped on foam covering was not cleanable and unsightly. Bedroom and/or bathroom moldings were scraped, scarred or chipped with exposed rough edges for residents R21 and R39.	21685		

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The floor tile grout was stained dark gray to black in the bathrooms utilized by R1, R37, R50 and R60.

Door handles were missing on the closet doors for R21 and R55.

R54's bedroom had a ceiling tile with large water stain.

The radiator covering in R37's room was bent, exposing a sharp edge.

Wall repairs were patched but not painted in the bedrooms for R14 and R55.

R21 and R28 had numerous holes in the bathroom and bedroom walls.

The DBG, interviewed on 4/10/14, at approximately 2:00 p.m. stated there was no preventative maintenance program for the facility. DBG stated he relied on the nursing or housekeeping staff to tell him when something needed repair or touch up. He stated the painting has fallen behind in the resident areas since the painters are working on the first floor where there are no residents.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could work with the director of building and grounds to develop a maintenance program to ensure damaged walls, floors, ceilings, and bedroom and bathroom fixtures are managed/repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance.

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TIME PERIOD FOR CORRECTION:
Twenty-One (21) Days.

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MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights

Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the facility did provide privacy during blood glucose monitoring for 2 of 3 residents (R16, R39) whose Accuchecks were observed.

Findings include:

On 4/7/14, at 4:01 p.m. licensed practical nurse (LPN)-A approached R16 while she was sitting in the day room at a table with three other residents and another resident at a table near by. The LPN stated to R16, "Can I bug you for a minute?" The LPN applied gloves, cleaned R16's finger with an alcohol wipe, poked R16's finger, obtained the blood sample, wiped R16's finger with a cotton ball then removed her gloves.

On 4/7/14, at 4:16 p.m. LPN-A entered R39's

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room with the roommate present in the room. The LPN applied gloves, set up the blood glucose machine and supplies, cleaned R39's finger with an alcohol wipe, poked R39's finger, obtained the blood sample, wiped R39's finger with a cotton ball then removed her gloves. The LPN did not pull the privacy curtain between the two residents or ask the resident or the roommate's permission to do the blood glucose check in each other's presence.

On 4/7/14, at 6:45 p.m. during an interview, LPN-A stated she usually takes residents to a private area but R16, "Can get a little feisty". LPN-A stated she should have pulled the curtain between the R39 and her roommate.

The director of nursing (DON), interviewed on 4/9/14, 10:15 a.m., stated blood glucose monitoring should not be done in the day room and residents should be provided privacy. The DON stated some residents were resistive to leaving the day room to have their blood sugars checked. "In the resident's room if the roommate had a problem with it then yes the curtain should be pulled."

A policy regarding providing residents privacy during blood glucose monitoring was requested but was not provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure privacy is maintained for each resident at all times.
The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance.

Minnesota Department of Health

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21855	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21855		