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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7Z8M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00048

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245045**

2.STATE VENDOR OR MEDICAID NO.
(L2) **695045100**

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

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 **6/25/2013** (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)
09/30

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

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (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

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
	76			
(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 :
Pat Halverson, Unit Supervisor — 6/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Nicole Steege, Program Specialist — 6/29/2013 (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)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07.02.2013 CO. 7Z8M

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2013
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on February 13, 2013, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required.

A Life Safety Code (LSC) Federal Monitoring Survey (FMS) was completed on March 21, 2013. Deficiencies were found, the most serious at a S/S level of F. As a result of the FMS, CMS informed the facility of the following remedy:

- Mandatory DOPNA, effective May 13, 2013

In addition, CMS also informed the facility that if DOPNA goes into effect, they would be subject to a loss of NATCEP for a two year period beginning May 13, 2013.

A health Post Certification Revisit (PCR) was completed on March 27, 2013 (by plan of correction), and the LSC and FMS PCR were completed on June 25, 2013. The PCR's found all deficiencies corrected and the facility was in substantial compliance as of June 25, 2013.

As a result, we are recommending the following to the CMS RO:

- Mandatory DOPNA, effective May 13, 2013 be discontinued effective June 25, 2013

This facility is also subject to NATCEP loss effective May 13, 2013 due to DOPNA.

See attached CMS-2567b's for the results of the March 27, 2013 and June 25, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5045

June 29, 2013

Mr. Richard Breuer, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

Dear Mr. Breuer:

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 June 25, 2013 the above facility is recommended for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 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,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 29, 2013

Mr. Richard Breuer, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

RE: Project Number S5045023

Dear Mr. Breuer:

On February 22, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 13, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

In addition, on March 21, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 3, 2013, CMS forwarded the results of the FMS to you and informed you that the following remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 13, 2013. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 3, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 13, 2013.

On March 27, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction, and on June 25, 2013, 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 the standard survey, completed on February 13, 2013, and

the FMS, completed on March 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 20, 2013. Based on our PCR's, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2013, and the FMS, completed on March 21, 2013, effective June 25, 2013.

As a result of the findings of the PCR's, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter dated April 3, 2013.

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 13, 2013 be discontinued effective June 25, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 13, 2013, is to be discontinued effective June 25, 2013. They will also notify the State Medicaid Agency that the denial of payment of all Medicaid admissions, effective May 13, 2013, is to be discontinued effective June 25, 2013.

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 the March 27, 2013 and the June 25, 2013 revisits.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245045	A. Building B. Wing	3/27/2013

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **03/22/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/22/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/22/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/22/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/22/2013**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **03/22/2013**
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:
	PH/NCS	6/29/13	12835	3/27/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/13/2013

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245045	A. Building 01 - MAIN BUILDING B. Wing	6/25/2013

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/25/2013	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 PS/NCS	Date: 6/29/13	Signature of Surveyor: 03005	Date: 6/25/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/11/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245045	A. Building B. Wing **01 - MAIN BUILDING**	6/25/2013

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	**05/13/2013**	ID Prefix	**06/20/2013**	ID Prefix	**05/13/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0018		LSC K0020		LSC K0025	
ID Prefix	**05/13/2013**	ID Prefix	**05/13/2013**	ID Prefix	**04/05/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0027		LSC K0029		LSC K0038	
ID Prefix	**04/12/2013**	ID Prefix	**04/1w2013**	ID Prefix	**04/05/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0048		LSC K0050		LSC K0056	
ID Prefix	**05/15/2013**	ID Prefix	**05/13/2013**	ID Prefix	**03/22/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0062		LSC K0071		LSC K0072	
ID Prefix	**05/13/2013**	ID Prefix	**05/13/2013**	ID Prefix	Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0074		LSC K0144		LSC	

Revieg ed By State A: ency	Revieg ed By	DateO	Si: nature of SurveyorO	DateO
	PS/NCS	6/29/13	03005	6/25/13
Revieg ed By CMS Rk	**Revieg ed By**	**DateO**	**Si: nature of SurveyorO**	**DateO**

Follog up to Survey Completed onO 3/21/2013

Chec. for any Uncorrected DeficienciesW7 as a Summary of Uncorrected Deficiencies (CMS-256w) Sent to the Facility? **YES** **Nk**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245045	A. Building B. Wing **02 - DINING/ACTIVITY**	6/25/2013

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **05/13/2013**	ID Prefix	Correction Completed **03/28/2013**	ID Prefix	Correction Completed **03/22/2013**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0038	
ID Prefix	Correction Completed **05/13/2013**	ID Prefix	Correction Completed **04/12/2013**	ID Prefix	Correction Completed **04/17/2013**
Reg. # **NFPA 101** LSC K0045		Reg. # **NFPA 101** LSC K0048		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **05/13/2013**	ID Prefix	Correction Completed **05/07/2013**	ID Prefix	Correction Completed **05/13/2013**
Reg. # **NFPA 101** LSC K0051		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/NCS	6/29/13	03005	6/25/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/21/2013

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: 7Z8M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00048

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245045**

2.STATE VENDOR OR MEDICAID NO.
(L2) **695045100**

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 **02/13/2013** (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)
09/30

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

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (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
	76			
(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 Johnson, HFE-NEII 03/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 04/08/2013 (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)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/09/2013 CO. 7Z8M

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on February 13, 2013, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after March 22, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5914

February 22, 2013

Mr. Richard Breuer, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

RE: Project Number S5045023

Dear Mr. Breuer:

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

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

<u>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;

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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (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 March 22, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 22, 2013 the following remedy will be imposed:

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

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.

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 May 13, 2013 (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 August 13, 2013 (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,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

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
	245045	A. BUILDING _____ B. WING _____	02/13/2013

RECEIVED
MAR 04 2013
MN Dept of Health
Duluth

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: 69	F 000	OK 3/5/13 PLH	
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 are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide choices related to bathing and when to get up in the morning for 1 of 3 residents (R21) reviewed for choices. Findings include:	F 242		

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

[signature] — CEO/Administrator — March 1, 2013

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

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F 242	Continued From page 1 R21, interviewed on 2/10/13, at 3:23 p.m., stated she gets a weekly shower but prefers a tub bath, and always took a tub bath at home. R21 also stated staff get her up in the morning when she wants to sleep. R21's diagnoses included osteoporosis and cardiac disease. The significant change minimum data set (MDS) dated 8/23/12, indicated it was "very important" for R21 to choose daily preferences between a tub bath, shower, bed bath and sponge bath. The quarterly MDS dated 11/5/12, indicated R21 had moderate cognitive impairment; had no behaviors; and required the physical help of staff with bathing. The activities of daily living (ADL) care plan dated 7/6/12, indicated R21 required the assist of one staff with bathing. The nursing assistant (NA) care plan indicated that R21 was to have a weekly tub bath on Friday mornings. Review of the Bath Type Detail Report from 12/20/13 through 2/8/13 indicated that R21 had a weekly shower during this time. On 2/12/13 NA -J stated R 21 had been taking a shower to be quicker because she would get cold. On 2/13/13, at 10:10 a.m. the registered nurse (RN)-D stated that she should be notified when R21 was cold in the morning and wanted a tub bath in the afternoon.	F 242	*Nurse Manager met with Resident #21 during survey regarding her choice for bathing and plan of care has been revised and updated with preference of bath and time of day.* *All of the residents could be affected by this practice. They are interviewed routinely by activity staff on admission and their choice is care planned, but they could change their minds.* *Any resident who is able to make choices will be asked by the NAR what their preference is prior to bath/shower. All direct care staff will be in-serviced on asking each resident prior to bath/shower what their preference it.* *Random resident interviews will be completed weekly for 1 month, then monthly for 3months concerning resident preferences and if staff is following the resident preference. The correction will be monitored by the ADON to ensure compliance.* *Monthly - Issues will be brought to Q.I. meeting with results of audits by the ADON/or designee.* *Quarterly – Results of audits will be brought to the LTC Q.A. meeting by the ADON for review and recommendations.*	*3/22/13*
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 2 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the openings in side rails for 4 of 4 residents (R91, R41, R61, R40) were within the recommended FDA guidelines to reduce the risk of entrapment The Guidance for Industry and FDA Staff; 3/10/06, recommended the spaces within a side rail, under the rail, between the rail supports, and between the rail and the mattress be less than 4 3/4 inches. During the entrance tour 2/10/13, R91's bed was observed to have upper half side rails in the up position on both sides of the bed. The spaces within the side rails were measured at 7 by 7.5 inches. R91 had diagnoses that included arthritis, shoulder pain and osteoporosis. R91 was receiving OxyContin (narcotic pain medication) 20 mg twice a day for shoulder pain. The significant change minimum data set (MDS) dated 1/9/13, indicated R91 was cognitively intact. The care plan dated 1/16/13, indicated that R91	F 323	*R40 was changed to a bed with legal side rails. R41 was changed to a bed with legal side rails. R61 was reassessed and his side rails were zip tied down on the bed. R91 was changed to a bed with legal side rails.* *Identifying other residents who could be affected by this was done by checking every bed in SHCC and identifying which residents were using the old beds with non-compliant side rails.* *Measures put into place are: Putting all non-compliant side rails down and zip tied them to the frame. Bed gaps were filled with gap guards. We continue to be on a plan to purchase 6 new beds every year until all older beds are replaced. On 2/27/13, the DON wrote a letter to our Foundation requesting their help in purchasing some of the beds to speed this process up. We have ordered a smaller side rail to trial and also a cover for a side rail that has an opening for the electric controls for some residents who may be able to use those controls. All staff will be educated on side rail use and bed gaps.* *Monitoring will be done monthly for 6 months checking random beds on each floor by an RN. Any issues will be corrected immediately and reported to the ADON for follow-up. The ADON is responsible.*	*3/22/13*

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F 323	Continued From page 3 used bilateral side rails with mesh covers to prevent entanglement in the side rail spaces. The Bed Rail Consent dated 5/22/12, indicated R91 used siderails with mesh coverings for bed mobility and for access to the bed controls. R91 was observed lying in bed with both half side rails in the up position on 2/11/13, at 8:55 a.m.. R91 demonstrated how she/he used the side rails for turning and stated she signed a form to get them. On 2/13/13, both half side rails were observed with mesh covers applied. R91, interviewed at 9:00 a.m., stated staff added the mesh coverings the day before. R91 stated that she can't get a hold on the side rail through the mesh covering. R91 added she had more shoulder pain when she tried to turn in bed without using the side rails. R41 was observed, on 2/10/13, at 4:09, p.m. with bilateral upper half side rails in the up position on the bed. R41 had diagnoses that included history of right hip fracture, right arm fracture, right knee fracture, left thigh pain and a history of falls. The admission MDS dated 11/19/12, indicated R41 was cognitively intact and required extensive assistance of 2 staff for transfers. The care plan dated 12/13/12, indicated R41 utilized mesh covered side rails for repositioning from side to the right side. R41 had impaired mobility related to right elbow and hip fracture with associated mobility impairment and pain.	F 323		

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F 323	Continued From page 4 On 2/11/13, at 8:55 a.m. R41's side rails were in the up position and the spaces between the bars measured 7 by 7.5 inches. R41 stated the side rails were used for turning in bed and she had signed a consent to have them. On 2/11/12, at 10 a.m. the side rails observed to be in the up position. On 2/12/13, at 2:30 p.m. the two upper side rails were observed to be in the up position. On the morning of 2/13/13, R41 was observed to be in a low bed without side rails. R41 was interviewed on 2/13/13, at 8:55 a.m., and stated the bed had been changed that morning. R41 said that she/he used the side rails to turn in bed and preferred to have side rails on the bed. Interview with the registered nurse (RN)- D on 2/13/13, at 9:00 a.m. indicated that they gave R41 a low bed per her request and planned to apply appropriate safe side rails after assessing them. R61, who had a history of falls from the bed, had two 1/2 upper side rails on the bed with spaces within the rails of greater than 4 and 3/4 inches. This placed R61 at risk for possible entrapment. On 2/10/13, at 4:40 p.m. R61 was observed lying in bed with two 1/2 side rails up on the bed. R61 stated he/she had the side rails due to falling out of bed once in the facility, and had a history of falling out of bed at home. R61 stated he/she came to the facility due to a fall with a broken hip, and used the rails to get in and out of bed and sit up. Both rails had four openings and the two center openings within the rails measured 7.25 inches wide x 7.5 inches high. R61's diagnoses included atrial fibrillation,	F 323		

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F 323	Continued From page 5 coronary artery disease (CAD), congestive heart failure (CHF), pneumonia, diabetes, degenerative joint disease (DJD), osteoporosis, glaucoma, and depression. A Side rail Assessment dated 12/10/12, indicated R61 had both upper rails per request. The assessment identified decreased endurance and pain as factors which limited side rail use and medical symptoms of atrial fibrillation, and polynephritis. Potential risks of the side rails included bruises, cuts, and scrapes. The summary indicated R61 expressed the desire to use the rails for mobility, rolling side to side, and help in and out of bed. He/she also expressed the rails provided comfort due to occasional night mares. R61 was capable of performing a return demonstration to use the rails, and the assessment noted "body exceeds the size of the rail openings and a consent is in the chart." The side rail assessment did not identify R61's history of falls or fall risk as a factor to determine safety. Review of Unexpected Event Reports indicated R61 had two falls in the facility (without injury) on 9/25/12, and 2/11/13. Both falls were due to attempted self transfers from the bed to the wheelchair (w/c). The significant change MDS dated 12/19/12, indicated R61 had no cognitive impairment; required the extensive assistance of two staff with bed mobility, transfers, ambulation, and toilet use; had a fall two to six months prior to admission; and had no falls since the prior assessment. The impaired mobility care plan revised 2/5/13, indicated R61 had a hospital return on 12/10/12, with diagnoses of shortness of breath,	F 323		

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F 323	Continued From page 6 pneumonia, right pleural effusion, pyelonephritis, congestive heart failure (CHF), and low potassium. On 2/5/13, R61 had shortness of breath with exertion and had a right pleural effusion with 1200 cc fluid removed. Interventions included one staff assist for transfers, bed mobility, to get into a sitting position, and two assist to boost up in bed. The care plan identified the side rail use. On 2/13/13, at 1:10 p.m. RN-B confirmed the spaces within R61's side rails were greater than 4 and 3/4 inches. RN-B stated it was thought that if residents were assessed and provided the risks/benefits of the side rails the rails with spaces greater than 4 and 3/4 inches could be used. RN-B further stated residents were not actually measured but were "visualized" to determine whether they would be an entrapment risk related to size. The Side rails and Resident Safety policy reviewed/revised 8/12/11, indicated to prevent resident injury by entrapment residents would be evaluated/assessed for risks associated with side rails. The policy indicated bed rails may pose a risk if certain specifications related to structure were not met, and directed staff to assess functional ability, history of falls, and physical size such as height, head size, etc. The policy did not identify what specifications related to structure would not be recommended. R40 was not assessed for safety with the use of one half siderail attached to the side of the bed. On 2/10/13, at 3:26 p.m. R40 was observed in bed with a 1/2 siderail raised on the upper right side of the bed. The mattress was moved over	F 323		

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F 323	Continued From page 7 exposing approximately 2 inches of the bed frame and springs. This created a large space between the mattress and the siderail of approximately 8 inches. R40's diagnoses included osteoarthritis, weakness, chronic obstructive pulmonary disease (COPD), asthma, diabetes, right shoulder injury, restless leg syndrome and a history of patellar (knee cap) and left wrist fracture, The quarterly MDS dated 12/14/12, indicated R40 was cognitively intact. R40 required the extensive assistance of one staff with transfers and bed mobility. R40 had one fall without injury since the previous assessment. The impaired mobility care plan dated 3/7/11, indicated R40 required the assistance of two staff to boost up in bed and the assistance of one staff to lift her legs into bed. R40 was able to turn herself from side to side when in bed. The siderail use care plan dated 1/13/11, indicated R40 used a right upper siderail for bed mobility and transfers. Risk factors were reviewed and R40 requested to continue using the siderail. The transfers care plan dated 4/11/12, directed staff to transfer R40 with the assistance of one staff and the gait belt in and out of bed. Use the Easy Stand (a mechanical lift that assists with standing) when fatigued. The Siderail Assessment and the Safety assessment both dated 9/18/12, indicated R40 was able to safely use the siderail and wished to use it at night and when taking naps only. R40 used the siderail for the bed controls and	F 323		

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F 323	Continued From page 8	F 323		

positioning in bed. R40 demonstrated the ability to safely use the siderail. R40 had previously signed a consent form indicating the risks of siderails. R40's body posed minimal risk for entrapment.

On 2/12/13, at 2:30 p.m. R40 was observed in bed with the upper 1/2 siderail raised. The siderail had two open areas within the rail. The first opening (nearest the head of the bed) measured 6 inches wide and 5 and 1/2 inches high. The second opening in the middle measured 4 and 1/2 inches wide and 5 and 1/2 inches high. A third opening was enclosed with the bed controls. Under the rail were two supports attaching the rail to the bed. The distance between the rail supports measured 8 inches. The distance between the rail and the mattress was 6 inches. The mattress had been pushed over again. The distance between the mattress and the wall was 2 inches. On 2/13/13, at 9:37 a.m. during an interview with R40 regarding how she used her siderail. R40 stated, "I use it to hold on to when I'm in bed and when I sit up."

On 2/13/13, at 9:39 a.m. nursing assistant (NA)-C indicated R40 used the siderail to get out of bed by holding onto it. The NA indicated the siderail was down when R40 got into bed, then up when R40 was in bed.

RN-D observed the bed and was interviewed on 2/13/12, at 10:35 a.m., and stated R40 was safe in the bed with rails when the mattress was in the correct place. RN-B moved the bed against the wall to hold the mattress against the side rail. RN-B stated it was not safe when the mattress was moved away from the side rail.

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 _____	02/13/2013

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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently monitor blood pressures (BP's) and administer a BP medication according to the physician ordered parameters for 1 of 10 residents (R4) whose medications were reviewed. Findings include:	F 329	*Resident #4 EMAR has been revised and updated with Blood Pressure monitoring prior to administering the medication as MD ordered.* *Any resident needing blood pressure parameters could be affected.* *Pharmacy will be notified, per fax, by the nurse or unit clerk when an order with parameters is ordered by the MD.* *Staff trained on med administration with parameters.* *Weekly – Audits will be conducted for any new blood pressure medications with parameters. Audits will continue weekly for 3 months and then revert to random.* *Monthly – Issues will be brought to Q.I. with results of audits, by the ADON/DON.* *Quarterly – Results of audits will be brought to LTC Q.A. meeting by the ADON/DON for review and recommendations.*	*3/22/13*

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F 329	Continued From page 10 R4's physician's orders dated 2/12/13, directed staff to administer diovan (antihypertensive medication) 80 mg daily and hold the medication if the SBP was <110. The order indicated the medication was started on 7/27/12. There was no evidence to indicate BP's were consistently obtained prior to holding or administering the medication. R4's diagnosis included hypertension (HTN). The quarterly Minimum Data Set (MDS) dated 1/18/13, indicated R4 had no cognitive impairment and had a diagnosis of HTN. Review of R4's BP monitoring and Electronic Medication Record (EMR) from 12/1/12, to 2/12/13, indicated as follows: During December 2012, diovan was not administered on 12/15, and 12/29; however, the BPs were not documented to indicate why the medication was held. The EMR further indicated that diovan was administered on 27 of the days with documented BP's on only nine of the days. In January 2013, diovan was held on 1/7, 1/8, 1/10, and 1/21, and was administered the rest of the 27 days. There were no BPs documented during the entire month. February 2013, diovan was administered on all 12 of the days with only one BP documented. The consultant pharmacist (CP) review dated 1/28/13, noted R4 had "frequent low BP readings and pulse" and currently used four medications for BP control. The CP recommended a trial dose reduction of another BP medication (metroprolol)	F 329		

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F 329	Continued From page 11 to 25 mg daily. On 2/13/13, at 1:10 p.m. the registered nurse (RN)-B stated she could not find evidence R4's blood pressures had consistently been checked prior to holding/giving the diovan. RN-B stated the physician had reviewed the CP recommendation from 1/28/13, and had decided not to reduce the metroprolol because the medication wasn't for BP it was for congestive heart failure (CHF). RN-B stated the physician also ordered a "cardiac echo" to get a better idea of R4's cardiac function. On 1/13/13, at 1:34 p.m. the CP stated he would expect the staff would check and document R4's BP prior to holding/giving the diovan medication as ordered by the physician.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist (CP) failed to identify and report an irregularity in the drug regimen related to monitoring blood pressures (BP's) as directed	F 428		

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F 428	Continued From page 12 by the physician prior to holding/administering a BP medication for 1 of 10 residents (R4) whose medications were reviewed. Findings include: The CP failed to identify the lack of monitoring related to parameters for administration of diovan (antihypertensive medication). R4's physician's orders dated 2/12/13, directed staff to administer diovan 80 mg daily and hold the medication if the SBP was <110. The order indicated the medication was started on 7/27/12. R4's diagnosis included hypertension (HTN). The quarterly Minimum Data Set (MDS) dated 1/18/13, indicated R4 had no cognitive impairment and had a diagnosis of HTN. Review of R4's BP monitoring and Electronic Medication Record (EMR) from 12/1/12, to 2/12/13, indicated the medication was administered on all days except 12/15/12 and 12/29/12 with BPs documented on only 9 days. During January 2013, diovan was administered all but 4 days, however, there were no documented BPs on the EMR. In February 2013, diovan was administered on all 12 with no documented BPs except one day (2/2/13). The consultant pharmacist (CP) dated 1/28/13, noted R4 had "frequent low BP readings and pulse" and recommended a trial dose reduction of another BP medication (metroprolol) to 25 mg daily. CP reviews for the last three months indicated no recommendations were made regarding lack of monitoring R4's BPs prior to holding/administering diovan.	F 428	***Resident #4 EMAR, has been revised and updated with blood pressure monitoring prior to administering BP medication.*** ***We checked residents' medication lists for any others that have parameters for giving blood pressure medication.*** ***Staff will notify Pharmacy when a MD orders parameters for a blood pressure med.*** ***Pharmacy will educate their pharmacists on residents' having parameters for blood pressure medications and watching for them with their medication reviews.*** ***Weekly – Pharmacist will review any medications with parameters within the EMAR for accuracy and document on a QA form. Issues will be reported to the DON for follow through. This will be done for one month, and if no issues, will go to a monthly review for 3 months and random checking with medication reviews after that.*** ***Results of pharmacy monitoring will be reported by a pharmacist at the quarterly LTC QA meeting.***	*3/22/13*

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F 428	Continued From page 13 On 2/13/13, at 1:10 p.m. the registered nurse (RN)-B stated she could not find evidence R4's blood pressures had consistently been taken prior to holding/giving diovan. RN-B stated the physician had reviewed the CP recommendation from 1/28/13, and had decided not to reduce the metroprolol because the medication wasn't for BP it was for congestive heart failure (CHF). RN-B stated the physician also ordered a "cardiac echo" to get a better idea of R4's cardiac function. On 1/13/13, at 1:34 p.m. the CP stated when he reviews medications he does review blood pressures that are documented in the EMR, but would not have checked to see if the BP's were being completed prior to holding/giving the diovan. The CP stated he would expect the staff would check the BP prior to giving the medication as ordered by the physician. The Medication Administration & Monitoring policy reviewed/revised 11/2012, indicated a pharmacist would complete a monthly review of each resident's medication regimen and report any concerns or issues including inadequate monitoring to the physician and DON.	F 428		
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		

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F 441	Continued From page 14 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 failed to ensure staff utilized proper hand hygiene techniques during a dressing change for 1 of 1 resident (R44) in the sample observed for wound care; and for 1 of 4 residents (R51) in the sample observed for incontinence care.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 15 Findings include: R44 was observed during a dressing change to an open wound on the left leg on 2/12/13, at 9:55 a.m.. The licensed practical nurse (LPN)-B removed dressings with visible serous aqueous drainage. LPN-B washed her hands, donned gloves and used Q tips to apply bacitracin to the open wounds and spread the bacitracin on the wound with her right hand. With the same gloved right hand, LPN-B touched the ointment bag, the clean dressings, the bag containing the dressing supplies, the clean Kling gauze wrap, the bag containing the Kling gauze wrap, the tape, scissors, a barrier cream box and the container holding all of the dressing supplies. LPN-B proceeded to help R44 finish dressing, still wearing the soiled gloves. LPN-B was interviewed on 2/12/13, at approximately 10:02 a.m., and estimated the size of the left leg wound to be 7 cm by 4 cm. At 10:05 a.m. LPN-B confirmed she did not change the right hand glove before touching multiple clean items during the dressing change. The infection control nurse, interviewed on 2/13/13, at 11:45 a.m., stated staff were to change gloves and wash hands after touching open wounds. The infection control policy last revised 8/3/11, listed indications for hand hygiene that included: "After contact with body fluids or excretions, non-intact skin, and wound dressings. Before and after removing any type of glove used in patient care. Every time gloves or other PPE are	F 441	***R51 was corrected by nurse talking to the aide after she was informed of the contamination during cares.*** ***R44 – The nurse realized her mistake with gloving after she did it and was able to tell manager what she should have done for correct procedure.*** ***Identifying residents who may be impacted would be all if staff did not perform procedures correctly.*** ***Measures to correct the deficient practice are: All staff educated on proper procedures for hand washing and glove use with cares and treatments.*** ***Monitoring performance 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 then go to monthly for 3 months and then to random audits. The ADON will be responsible. Results will be reported to the quarterly LTC QA committee meeting.***	*3/22/13*

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F 441	Continued From page 16 removed." R51 was not provided appropriate infection control during incontinence care. On 2/12/13, from 8:52 a.m. until 9:36 a.m., R51 was observed during incontinence care. The nursing assistant (NA)-H was observed to wash hands, don gloves and wash R51's perineal area from the front. R51 was assisted onto the left side and and was observed to be incontinent of stool. NA-H cleaned the rectal area and positioned the lift sling before placing the soiled cloth in a basin. Still wearing the same gloves, adjusted the lift sling, positioned a new clean brief under R51, rolled her to her right side, secured her brief, adjusted the sling again and handled the bed linens and clothing before removing the soiled gloves and washing hands. NA-H donned clean gloves, wrung out the soiled wash cloth and deposited it in the soiled laundry bag, while wearing the same soiled gloved, opened the door to the hall, brought the lift in the room, shut the door, positioned R51's Broda chair, unplugged the electrical cord for tube feeding, and fastened two loops of the sling onto the lift before washing hands. NA-H was interviewed on 2/12/13 at 9:37 a.m. and stated the soiled gloves were not changed before touching clean surfaces. The assistant director of nursing was interviewed on 2/13/13 at 11:33 a.m., and stated hand washing and gloving should have be completed after touching anything that has the potential of being contaminated. The infection control policy for hand hygiene,	F 441		

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F 441	Continued From page 17 dated as reviewed and revised 8/3/11, directed staff to perform hand hygiene after contact with body fluids or excretions, and, after touching any item used by or for a resident.	F 441	*The LTC biller corrected the demand bill claim with the Medicare Intermediary, Noridian, on 2/13/2013. Records were mailed out to Noridian as requested on 2/26/2013. The resident's representative will be notified immediately via mail when we receive a determination. A refund was mailed to the responsible party on 2/15/2013.* *A review of all other residents that requested demand bills in the past 12 months was performed and found to be appropriate according to regulations.* *The biller completed a review of the policy and procedure for Demand Bill Requests on 2/22/2013. Copies of all non-coverage notices issued to residents will be made for the business office. Nursing will notify the biller and the department director of all requests for demand bills. The director will verify that bills/statements are on hold before they are printed on the regular monthly basis.*	*2/27/13*
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 2 residents (R98) who requested a demand bill was not billed for covered services while a Medicare decision was pending. Findings include: R98 was admitted 9/19/12. The Skilled Nursing Facility (SNF) Determination and Continued Stay form dated and signed by R98's representative on 9/21/12, indicated the representative was notified skilled Medicare A services would not be covered after 9/24/12. A demand bill was not requested at that time. The registered nurse (RN)-C, interviewed on 1/11/13, at 12:01 p.m., stated the Quality Improvement Organization (QIO) notified the facility the representative had changed their mind and requested an appeal/demand bill on 9/22/12.	F 492		

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F 492	Continued From page 18 RN-C stated a demand bill was submitted on 10/30/12, and the decision was still pending. RN-C provided a billing statement which indicated R98 had been billed for services received between 9/19/12, and 10/29/12. RN-C verified R98 had been billed for all services, and stated the bill was paid in full on 11/2/12. The Long Term Care Demand Bill Requests policy dated 12/17/09, indicated the nursing staff would notify the business office when a request for demand bill has been made, and the business office would place the resident's statement on a hold status.	F 492		

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

F 50 45020

PRINTED: 02/22/2013
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
	245045	A. BUILDING 01 - MAIN BUILDING B. WING _____	02/11/2013

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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 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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 not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST PAUL, MN 55101-5145	K 000	POC ok JB 3-8-13 RECEIVED MAR - 6 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 03.25.2013

EXIT: 02.13.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO/Administrator	March 4, 2013

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

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K 000	Continued From page 1 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 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 sparated 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 76 beds and had a census of 71 at the time of the survey.	K 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of available documentation and interview, it was determined that fire drills were not conducted at as required by LSC(00) Section 19.7.1.2. This deficient practice could affect all occupants including residents, visitors and staff in the event of a fire emergency. Findings include: On 2-11-13 at the conclusion of the inspection, at approximately 10:30AM, based on a review of available fire drill documentation it was determined that fire drills were not conducted as required. The facility is currently under renovation and construction of an addition on the hospital side. The hospital is not 2 hour fire rated separated from the nursing home. Because of the construction, the entire facility is under interm Life Safety Code measures, that would require more	K 050	***CMH has conducted one (1) fire drill on Wednesday, 2/20/2013 at 11:45 p.m. (night shift). The simulated conditions included a fire in a patient room requiring staff to perform the RACE (rescue, alarm, confine, extinguish) method to rescue a patient (mannequin) in bed using a two-person carry evacuation technique to evacuate the smoke compartment.*** ***Additional fire drills are planned for day and afternoon shifts.*** ***Monday, March 4, 2013 @ 4:40 p.m.*** ***Friday, March 8, 2013 @ 9:15 a.m.*** ***CMH will conduct at least three (3) fire drills, one (1) per shift for the first quarter of 2013 by March 9, 2013. On an ongoing basis, CMH will conduct fire drills at unexpected times under varying conditions, at least quarterly on each shift.*** ***The Safety Coordinator will be responsible for conducting and documenting all fire drills. In addition, the Safety Coordinator will review and assess the effectiveness of fire drills and response procedures with the Safety Committee.***	*3/9/13*

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 _____	02/11/2013

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 050	Continued From page 3 then the one per shift per quarter drills. 2nd quarter 2012 no night shift drill 3rd quarater of 2012 no day or night shift drills 4th quarter of 2012 no night or afternoon shift drills. 1st quarter of 2013 No drills, yet. Note: Lack of fire drills were also cited at the time of last inspection 11-29-11. This deficient practice was confirmed by the facility Director of Maintenance (PC) and the facility Safety Officer at the time of exit.	K 050		