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: 9TNG
Facility ID: 00776

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245225**

2.STATE VENDOR OR MEDICAID NO.
(L2) **685740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SLEEPY EYE CARE CENTER**
(L4) **1105 3RD AVENUE SOUTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 10/22/2013 (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)
06/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (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
	65			
(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):

Post Certification Revisit by review of the facility’s plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective September 30, 2013, the facility is certified for 65 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 10/22/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/26/2013 (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
12/01/1978
(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
12/04/2013
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5225 December 26, 2013

Ms. Pamela Adam, Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, Minnesota 56085

Dear Ms. Adam:

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 September 30, 2013, the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Ms. Pamela Adam, Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, Minnesota 56085

November 1, 2013

RE: Project Number S5225023

Dear Ms. Adam:

On September 4, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 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.

On October 22, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 23, 2013 the Minnesota Department of Public Safety completed a 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 August 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2013, effective 09/30/2013 and therefore remedies outlined in our letter to you dated September 4, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kathryn Serie

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

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245225	A. Building B. Wing	10/22/2013

Name of Facility	Street Address, City, State, Zip Code
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	**09/30/2013**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**09/30/2013**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	**09/30/2013**
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**09/30/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**09/30/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**09/30/2013**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**09/30/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	**09/30/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**09/30/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**09/30/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	**09/02/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**09/30/2013**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	**09/03/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/KJ	11/01/2013	03048	10/22/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/15/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245225	A. Building B. Wing 01 - SLEEPY EYE CARE CENTER	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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 K0056	Correction Completed 09/17/2013	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/KJ	**Date:** 11/01/2013	**Signature of Surveyor:** 19251	**Date:** 10/23/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/16/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 9TNG
Facility ID: 00776

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245225**
2. STATE VENDOR OR MEDICAID NO. (L2) **685740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SLEEPY EYE CARE CENTER**
(L4) **1105 3RD AVENUE SOUTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **08/15/2013** (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) **06/30**

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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 :
Joseph Garvey, HFE NE II 09/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Enforcement Specialist 12/04/2013 (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 **12/01/1978** (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 **12/04/2013** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

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

CCN# 245225

At the time of the standard survey completed August 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 2996

September 4, 2013

Ms. Pamela Adam, Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, Minnesota 56085

RE: Project Number S5225023

Dear Ms. Adam:

On August 15, 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;**

<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:

Kathryn Serie, Unit Supervisor
Division of Compliance Monitoring
Licensing and Certification Section
1400 E. Lyon Street
Marshall, MN 56258

Office: 507-537-7158
Fax: 507-537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 24, 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 September 24, 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 November 15, 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 February 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124   Fax: 651-215-9697

Enclosure
cc: Licensing and Certification File

Sleepy Eye Care Center
1105 3rd Ave SW
Sleepy Eye, MN 56085
Provider ID # 245225

Plan Of Correction For CMS-2567

F156
It is the practice of the Sleepy Eye Care Center to inform each resident periodically of the right to contact outside agencies for grievances.

All residents were given an informational sheet informing them of the Ombudsman's name and contact information. This sheet was posted on residents' closet doors August 30th.

Currently we have posters posted in facility with contact information and talk about it at time of admission. Facility will have a meet and greet with ombudsman annually.

Social Service Director is responsible for compliance.

The facility alleges that it will be in substantial compliance and complete all action items by September 30, 2013.

F164
It is the policy of the Sleepy Eye Care Center that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

All nursing staff will be in-serviced on Notice of Privacy Practices on September 24th and 26th.

Silver Chair training was set up to in-service all staff on resident rights, Elder Justice Act, and Abuse prevention policy and procedure.

Director of Nursing is responsible for compliance.

The facility alleges that it will be in substantial compliance and complete all action items by September 30, 2013.

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Sleepy Eye, MN 56085
Provider ID # 245225

Plan Of Correction For CMS-2567

F166
It is the policy of the Sleepy Eye Care Center to promptly resolve grievances.

Resident #9

Facility Policy for solving grievances was reviewed. Resident #9 was interviewed by staff. Resident states she did have a pair of earrings missing and it was reported about 10 months ago. A VA was filed with the Minnesota Department of Health on 8/19/2013 and an investigation was started. It was found that staff involved in incident are no longer employed at facility. Sleepy Eye Police Department was notified of missing earrings per policy.

Interdisciplinary team, social service, and Executive Director will review grievances daily at morning meeting to ensure that grievances are promptly resolved.

Silver Chair training was set up to in-service all staff on resident rights, Elder Justice Act, and Abuse prevention policy and procedure.

Social Service Director is responsible for overall compliance along with communicating results of grievances at QA meeting.

The facility alleges that is will be in substantial compliance and complete all action items by 9/30/2013.

F225
It is the policy of the Sleepy Eye Care Center to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.

Facility policies and procedures for abuse prohibition were reviewed. The administrator was notified of missing earrings on 8/12/13 and the Sleepy Eye Police Department was notified on 8/19/2013.

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Interdisciplinary team, social service, and Executive Director will review all incident reports daily at morning meeting to ensure that the administrator and other officials have been notified in accordance with State law.

Nursing staff will be inserviced on the Concern or Problem Resolution policy on September 24th and 26th.

Silver Chair training was set up to in-service all staff on resident rights, Elder Justice Act, and Abuse prevention policy and procedure.

The Executive Director is responsible for overall compliance along with communicating results of incident reporting to QA meeting.

The facility alleges that is will be in substantial compliance and complete all action items by 9/30/2013.

F226
It is the policy of the Sleepy Eye Care Center to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.

Facility policies and procedures for abuse prohibition were reviewed. The administrator was notified of missing earrings on 8/12/13 and the Sleepy Eye Police Department was notified of missing earrings on 8/19/2013.

Interdisciplinary team, social service, and Executive Director will review all incident reports daily at morning meeting to ensure that the administrator and other officials have been notified immediately in accordance with State law.

Silver Chair training was set up to in-service all staff on resident rights, Elder Justice Act, and Abuse prevention policy and procedure.

The Executive Director is responsible for overall compliance along with communicating results of incident reporting to QA meeting.

The facility alleges that is will be in substantial compliance and complete all action items by 9/30/2013.

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Plan Of Correction For CMS-2567

F279
It is the policy of the Sleepy Eye Care Center to complete a care plan that will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible.

Resident #52

Care plan has been reviewed and updated to include the diagnosis of diabetes and interventions pertaining to diagnosis.

Resident #24

Care plan has been reviewed and updated with recommendation by dentist to brush teeth and rinse gums after eating for tissue health and to freshen breath.

Resident #54
Care plan has been reviewed and updated to include risk factors, goals, and interventions for the use of cardiac medications and anticoagulant therapy.

Reviewed all care plans and diagnosis's to ensure that appropriate interventions are on care plan. Assessments and care plans were updated to reflect residents' current status.

Staff will be educated on September 24 on including diagnosis' and interventions on plan of care and to include instructions by doctors and dentists so that all staff are aware.

A random audit will be performed by the Interdisciplinary Team weekly on 10% of residents weekly to ensure that diagnosis' and interventions and instructions by doctors and dentists are on the care plan.

The facility alleges that it will be in substantial compliance and complete all action items by 9/30/2013.

Director of Nursing is responsible for compliance along with communicating results of audits to QA meeting.

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Plan Of Correction For CMS-2567

F280
It is the policy of the Sleepy Eye Care Center to revise and update the plan of care as the resident changes.

Resident #58
Care plan was reviewed and updated to include type of pain, interventions for pain management, and a measurable goal for resident due to leg pain.

Resident #39
Care plan was reviewed and updated to include current diagnosis for pain.

Resident #31
Reviewed and updated care plan to include current behaviors exhibited by resident.

Reviewed and revised pain management policy. Policy now states that pain will be monitored for each resident daily, every shift on the Treatment Administration Record. The policy now states to initiate and/or update care plan to include type of pain, required monitoring including pain management plan and a measureable goal relating to the pain management plan.

All resident care plans were reviewed and updated according to new pain management policy.

A random audit will be performed by the Interdisciplinary Team weekly on 10% of residents to ensure that pain is being monitored for each resident daily, every shift and care plans will be audited to ensure that they include type of pain, required monitoring including pain management plan and a measureable goal relating to the pain management plan.

All resident care plans were reviewed and updated to include all behaviors exhibited by resident.

The facility alleges that it will be in substantial compliance and complete all action items by 9/30/2013.

Director of Nursing is responsible for compliance along with communicating results of audits to QA meeting.

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Plan Of Correction For CMS-2567

F309
It is the policy of the Sleepy Eye Care Center that all residents have the right for appropriate pain assessment and pain management. All residents will be evaluated for indicators or a history of pain for the MDS 3.0 on admission, quarterly, with a significant change in status, and with the new onset of potential pain or discomfort. Data will be collected through resident interviews, staff interviews and observations.

Resident #58
Care plan was reviewed and updated to include type of pain, interventions for pain management, and a measurable goal for resident due to leg pain.

Resident #39
Reviewed care plan. Set up to monitor pain every shift daily.

Reviewed and revised pain management policy. Policy now states that pain will be monitored for each resident daily, every shift on the Treatment Administration Record. The policy now states to initiate and/or update care plan to include type of pain, required monitoring including pain management plan and a measureable goal relating to the pain management plan.

All resident care plans were reviewed and updated according to new pain management policy.

A routine audit will be performed by the Interdisciplinary Team weekly on 10% of residents to ensure that pain is being monitored for each resident daily, every shift and care plans will be audited to ensure that they include type of pain, required monitoring including pain management plan and a measureable goal relating to the pain management plan.

All nursing staff will be inserviced on Septmeber 24th and 25th on new pain management policy and on how to identify signs and symptoms of pain and reporting of pain.

The facility alleges that it will be in substantial compliance and complete all action items by 9/30/2013.

Director of Nursing is responsible for compliance along with communicating results of audits to QA meeting.

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F312
It is the policy of the Sleepy Eye Care Center to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Resident #24

Reviewed care plan and was found to be appropriate for resident.

All nursing staff will be inserviced on providing oral cares to all residents according to their care plan on September 24th and 26th.

Routine audits for dental care will be done weekly with results reported to the facility QA team.

The facility alleges that it will be in substantial compliance and complete all action items by 9/30/2013.

Director of Nursing is responsible for compliance along with communicating results of audits to QA meeting.

F329
It is the practice of the Sleepy Eye Care Center to ensure each resident's drug regimen is free from unnecessary medications.

Resident #31
Care plan was updated and revised to reflect current behaviors.

Nursing staff will be inserviced on behaviors and the charting of all behaviors on September 24th and 26th.

Routine audits will be done weekly by IDT team to ensure that current behaviors are being charted and care planned.

The facility alleges that it will be in substantial compliance and complete all action items by 9/30/2013.

Director of Nursing is responsible for compliance along with communicating results of audits to QA meeting.

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F356
It is the policy of the Sleepy Eye Care Center to post the following information on a daily basis: facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift (registered nurses, LPNs, and certified nursing assistants), and resident census.

Reviewed policy and procedure. New form is now being used per policy and includes actual hours worked.

The facility alleges that is has been in compliance since September 2nd.

The Director of Nursing is responsible for compliance.

F371
It is the policy of the Sleepy Eye Care Center to store, prepare, distribute and serve food under sanitary conditions.

Policy on Cleaning Instructions for Slicer and policy of Food Storage was reviewed.

Dietary staff will be inserviced on the policy of Cleaning Instructions for Slicer and the importance of preparing food under proper sanitary conditions and cleaning equipment after use at monthly dietary meeting on September 17, 2013.

Dietary staff and nursing staff will be inserviced by September 24 on the policy of Food Storage and making sure that opening date is labeled on each product according to policy, including having the date pulled from freezer on Kemps product and kept in the box until empty.

Weekly audits will be done ensure that the meat slicer is proper cleaned and that Kemps box has the date that it was removed from freezer.

The facility alleges that it will be in substantial compliance and complete all action items by 9/30/2013.
Dietary manager is responsible for overall compliance.

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F465
It is the policy of the Sleepy Eye Care Center that a clean, safe and sanitary environment is to be maintained for residents and that the workplace will be maintained in a clean and sanitary condition.

North hallway and resident #28's carpets were shampooed.

Routine carpet cleaning was set up on TELS, which is our preventative maintenance program.

Weekly audits will be done to ensure that hallways and resident's rooms are clean and sanitary.

The facility alleges it has been in substantial compliance since September 3.

Director of Environmental Services is responsible for overall compliance.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING ____ B. WING ____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	approved on 9/23/13 xms RECEIVED SEP 18 2013 Minnesota Department of Health Marshall	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela Adams
TITLE: Administrator
(X6) DATE: 9/17/2013

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.

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 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156		

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to inform each resident periodically of the right to contact outside agencies for grievances which had the potential to affect 42 of 42 residents residing in the facility. Findings include: During initial interview with R26, a resident council representative, on 8/13/13 at 9:30 a.m., R26 stated she was unaware who could be contacted outside of the facility if she had a grievance or concern. R26 stated she was unaware she was able to contact an outside agency and was unaware of the name of the regional ombudsman. R26 stated she did not recall any staff having identified who the ombudsman was or how to contact the outside advocate.	F 156		

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F 156	Continued From page 3 During interview with R10 on 8/14/13, at 1:25 p.m. R10 stated she was not aware of who the State ombudsman was or what the State ombudsman's purpose was. R10, who stated she frequently attended resident council meetings, reported she did not recall any discussion regarding the State ombudsman or how to contact someone from the State ombudsman agency. R10 stated she was not sure what to do if she needed to contact someone outside of the facility if she had a grievance. During interview with the facility's social service director on 8/14/13 at 11:10 a.m., she stated the facility usually discussed how residents could contact outside agencies once annually at the March resident council meeting. During review of the resident council notes the social service director stated she had not been present at the March 2013 resident council meeting, and verified the minutes lacked documentation reflecting this information had been discussed. Further, the social service director verified only residents attending the resident council meeting would have been informed about how to contact the State ombudsman, otherwise that information was only discussed on admission. There was no current system in place to inform residents about the State ombudsman program other than during the admission process, or by attendance at the March resident council meetings.	F 156		
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.	F 164		

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F 164	Continued From page 4 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. 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 document review, the facility failed to maintain privacy and/or confidentiality when discussing medication information for 1 of 4 residents (R75) reviewed for privacy. Findings include: R75's privacy was not maintained on 8/13/13, while receiving information on an antidepressant medication.	F 164		

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F 164	Continued From page 5 During an observation on 8/13/13 at 3:32 p.m., registered nurse (RN)-E was sitting on a chair in R75's room with the room door wide open. RN-E was talking to R75 in a loud tone of voice about an antidepressant medication. RN-E was asking R75 if he was okay with taking this medication and requesting his consent to take the antidepressant medication. RN-E continued to explain the side effects of the medication in a loud tone of voice in R75's room, while door remained wide open. During this observation, visitors, staff members and other residents were observed walking or wheeling by in the hallway outside R75's room. R75 requested to use the bathroom at 3:35 p.m. RN-E left the resident's room and returned with help, shutting the door at that time. During an interview with licensed practical nurse (LPN)-B on 8/15/13, at 8:40 a.m., LPN-B confirmed residents and family members should be taken to a private place to talk to them about confidential information. During an interview with social services (SS)-A on 8/15/13, at 9:01 a.m., SS-A confirmed the facility policy was to discuss confidential information in a private area. SS-A stated residents and family members should be taken to a private place and doors should be shut whenever staff were discussing private information with them. The director of nursing (DON) was interviewed on 8/15/13, at 8:45 a.m. and confirmed current facility policy related to confidential information. The DON stated she would have expected staff to take R75 and/or family members to a private area to discuss medication usage, and would	F 164		

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F 164	Continued From page 6 have expected them to close doors to prevent any privacy/confidentiality breaches. The facility's policy titled, Notice Of Privacy Practices dated 4/1/03, directed staff to always consider where they were talking about confidential information such as public areas: dining room, hallways, elevators.	F 164		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to respond to grievances with prompt investigation, resolution, and follow up, for 1 of 4 residents (R9) reviewed for missing property. Findings include: R9 reported in an interview on 8/12/13, at 4:46 p.m. that she was missing a pair of earrings that she had received from a relative. R9 stated the earrings had been missing for about 10 months and stated that although she'd reported the missing property, she had not heard anything further as to whether or not they were found, or what else was being done. R9's quarterly Minimum Data Set (MDS) assessment dated 7/30/13, identified her as	F 166		

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F 166	Continued From page 7	F 166		

having a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition and the BIMS also identified her as free of long or short term memory problem.

During an additional interview with R9 on 8/14/13, at 1:30 p.m., R9 again stated she had been missing a pair of gold earrings that had been given to her by a relative. R9 stated she thought the earrings were worth about $400.00 and also had sentimental value. R9 stated she reported the missing earrings to one of the nurses but could not recall which one. R9 stated the earrings were still missing and no one had ever gotten back to her about the missing items.

During interview with the director of nursing services (DON) on 8/14/13, at 1:45 p.m. she stated she recalled R9 reporting some missing property awhile ago. The DON stated, "I think it was jewelry, and I'm not sure what the outcome was. I think I remember the family had taken them or something"? The DON stated she had not heard anything further about the missing property since the resident's report.

On 8/15/13, at 9:00 a.m. R9's family member was interviewed by telephone and stated he recalled his mother reporting missing earrings to the charge nurse, along with a pair of prescription glasses. R9's family member stated the facility had never contacted him or any other family since regarding any resolution to the missing property. R9's family member stated the earrings were important to his mother because they had been his grandmother's earrings.

Missing property logs maintained by the social service director (SSD) were reviewed, however,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING ______ B. WING ______	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(X4) ID PREFIX TAG	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 166	Continued From page 8 the logs failed to identify R9's missing property. The social service director verified during interview on 8/15/13, at 11:00 a.m. that the missing property logs did not mention R9's missing earrings. The SSD stated the missing property should have been logged, reported and investigated, but was not. On 8/15/13, at approximately 3:00 p.m. the DON provided a Progress Note dated 10/27/12, for the surveyor's review. The Progress Note, written by licensed practical nurse-A, indicated R9 had reported she was missing two pair of earrings. The facility's Concern or Problem Resolution Policy, revised 9/10, directed staff as follows: "1. Resident, family members, responsible parties, or other individuals on the resident behalf, have the right to file a grievance with the facility anytime, without fear of retribution. 2. Grievances can be filed verbally or in writing, using the Concern or Problem Resolution Form. The forms are to be made available at all nurses' stations, and included in the admission packet. 3. Grievances can be submitted to the social worker, executive director/resident director, or any other manager/supervisor. 5. Grievances will be routed and tracked by social services. They will be given to the appropriate department manager for follow-up, according to the nature of the concern. 6. Grievances will be responded to within 72 hours for non-emergency concerns. The facility will notify the complainant to provide updates on	F 166		

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F 166	Continued From page 9 resolution of the complaint. 7. The manager responsible for investigating and resolving the concern will complete the Resolution Form, including a plan for resolution. 8. The complainant will be informed of the final outcome and resolution. All communications will be documented on the Concern or Problem Resolution Form. Attach any relevant/supporting documentation to the form. 9. All forms are to be reviewed by the executive director/resident director. 10 Individuals not satisfied with the resolution will be directed to the executive director/resident director, who will evaluate the outcome with the concerned party. 11. Grievances and information from the Concern or Problem Resolution Form may lead to further investigation for alleged or potential abuse, neglect, maltreatment, or misappropriation of funds. 12. A file for grievance will be maintained by the social services/resident director or designee. 13,. Social services/resident director will utilize a tracking system of all complaints to ensure proper follow-up."	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225		

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F 225	Continued From page 10	F 225		

mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to immediately report potential misappropriation of property to the State agency

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F 225	Continued From page 11 (SA), and failed to thoroughly investigate the allegation for 1 of 4 residents (R9) reviewed for missing personal property. Findings include: R9 reported in an interview on 8/12/13, at 4:46 p.m. that she was missing a pair of earrings that she had received from a relative. R9 stated the earrings had been missing for about 10 months and stated that although she'd reported the missing property, she had not heard anything further as to whether or not they were found, or what else was being done. R9's quarterly Minimum Data Set (MDS) assessment dated 7/30/13, identified her as having a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition and the BIMS also identified the resident as free of long or short term memory problems. During an additional interview with R9 on 8/14/13 at 1:30 p.m., R9 again stated she had been missing a pair of gold earrings that had been given to her by a relative. R9 stated she thought the earrings were worth about $400.00 and also had sentimental value. R9 stated she had reported the missing earrings to one of the nurses but could not recall which one. R9 stated the earrings were still missing and no one had ever gotten back to her about the missing items. During interview with the director of nursing services (DON) on 8/14/13 at 1:45 p.m. she stated she recalled R9 having reported missing property awhile ago. The DON stated, "I think it was jewelry, and I'm not sure what the outcome was. I think I remember the family had taken	F 225		

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F 225	Continued From page 12 them or something?" The DON stated she had not heard anything further about the missing property since the resident's report. On 8/15/13, at 9:00 a.m. R9's family member was interviewed by telephone and stated he recalled his mother reporting missing earrings to the charge nurse, along with a pair of prescription glasses. R9's family member stated the facility had never contacted him or any other family member since the initial report, regarding any resolution to the missing property. R9's family member stated the earrings were important to his mother because they had been R9's mother's earrings. Missing property logs maintained by the social service director (SSD) were reviewed, however, the logs failed to identify R9's missing property. The social service director verified during interview on 8/15/13, at 11:00 a.m. that the missing property logs did not mention R9's missing earrings. The SSD stated the missing property should have been logged, reported and investigated, but was not. On 8/15/13, at approximately 3:00 p.m. the DON provided a Progress Note from the resident's record dated 10/27/12, for the surveyor's review. The Progress Note which had been documented by licensed practical nurse-A, indicated R9 had reported she was missing two pair of earrings. The facility's Concern or Problem Resolution Policy revised 9/10, included: "Grievances and information from the Concern or Problem Resolution Form may lead to further investigation for alleged or potential abuse, neglect, maltreatment, or misappropriation of funds."	F 225		

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policies related to immediate reporting and investigation of allegations of potential misappropriation of property, for 1 of 4 residents (R9) who reported missing personal property. Findings include: The facility's Concern or Problem Resolution Policy revised 9/10, included: "Grievances and information from the Concern or Problem Resolution Form may lead to further investigation for alleged or potential abuse, neglect, maltreatment, or misappropriation of funds." The facility's Resident/Client/Participant Protection Policy and Procedure revised 12/12, included the following: "Section D, part 2. Definitions: Identified misappropriation of property to include the intentional taking, misplacement, carrying away, using, transferring, concealing or retaining possession of a residents moveable property without the resident's consent." Section G of the policy Reporting and Response	F 226		

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F 226	Continued From page 14	F 226		

identified the following:

"a. Employees must always report alleged abuse/neglect (i.e. incidents, mistreatment, abuse, neglect, injuries of unknown origin, and misappropriation of resident property) immediately to the supervisor or the building supervisor.

b. The executive director or designated representative must be contacted immediately by the supervisor or reporter regarding all allegations of abuse/neglect. immediate reporting may be reported via voice mail, answer machine, or fax. Document date and time of notification.

c. Director of Nursing will be contacted per protocol and will involve social services or designee. Note: Failure to report can make you just as responsible for the abuse, (See state specific section for details on reporting to State Agencies).

d. If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law. If the abuse is substantiated, it will be reported to the registry or licensing board."

R9 reported in an interview on 8/12/13, at 4:46 p.m. that she was missing a pair of earrings that she had received from a relative. R9 stated the earrings had been missing for about 10 months and that although she'd reported the missing property, she had not heard anything further as to whether or not they'd been found.

During another interview with R9 on 8/14/13, at 1:30 p.m. R9 again stated she had been missing

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a pair of gold earrings that had been given to her by a relative. R9 stated she thought the earrings were worth about $400.00, and also had sentimental value. R9 stated she reported the missing earrings to one of the nurses but could not recall which one. R9 again stated the earrings were still missing and no one had ever gotten back to her about the missing items.

R9's 7/30/13 quarterly Minimum Data Set (MDS) assessment identified her with a Brief Interview for Mental Status (BIMS) score of 14 identifying her as having intact cognition and as free from long or short term memory problems.

On 8/15/13, at 9:00 a.m. R9's family member was interviewed by telephone and stated he recalled his mother reporting missing earrings to the charge nurse, along with a pair of prescription glasses. R9's family member stated the facility had never contacted him or any other family member with any resolution to the missing property. R9's family member stated the earrings were important to his mother because they had been R9's mother's earrings.

During a review of the facility's Vulnerable Adult (VA) reports, there was no report related to R9's missing property. The missing property had not been reported to the SA, nor was the problem thoroughly investigated.

The social service director verified on 8/15/13, at 11:00 a.m. that the missing property should have been logged, reported, and investigated, but was not.

The director of nursing verified during interview on 8/15/13, at 2:30 p.m. there had been no VA

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 16 report submitted regarding R9's earrings, and verified an investigation had not been conducted. During interview with the facility's administrator at 2:45 p.m. on 8/15/13, she stated she was unaware of any missing property for R9 and stated if a report had been filed it would have come across her desk to sign. The administrator verified there had not been a report filed or an investigation conducted.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 279		

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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
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F 279	Continued From page 17 review, the facility failed to develop comprehensive care plan interventions to direct patient care for 1 of 5 residents (R54) reviewed for unnecessary medications; for 1 of 1 resident (R52) reviewed with diabetes; and for 1 of 1 resident (R24) initiated for review due to dependence on staff for oral/dental hygiene care. Findings include: R54's care plan was not developed to identify risk factors, goals, and interventions for the use of cardiac medications and anticoagulant therapy. R54 was admitted to the facility on 2/7/13, and had diagnoses that included anxiety state, hypertension, cardiac dysrythmia, dementia, memory loss and depression. R54's medication regimen included Amlodipine 10 mg (millgrams), everyday for hypertension; Digoxin 0.125 mg, every other day for atrial fibrillation; Lasix 40 mg, every day for congestive heart failure; and coumadin 4 mg everyday for atrial fibrillation. R54's care plan last revised 6/29/13, did not identify any cardiac risk factors, goals, or interventions and failed to identify the risks associated with the use of anticoagulation therapy, or interventions for monitoring of potential side effects. An interview conducted on 8/14/13, at 11:20 a.m. RN-B (case manager) verified R54 had diagnoses including: atrial fibrillation, hypertension, and congestive heart failure. RN-B stated R54 had been recieving routine cardiac medications for the diagnoses. RN-B verified the care plan lacked any problem, goals, or interventions for R54's cardiac issues.	F 279		

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F 279	Continued From page 18	F 279		

During interview on 8/14/13, at approximately 11:40 a.m. the DON verified R54's care plan lacked any risks, goals, or interventions for cardiac compromise.

R24's care plan last revised 5/19/13, indicated R24 needed physical assistance of one with personal hygiene care but did not include specific directions for oral care. Care of the resident's partial dentures had been documented on a dental referral form from the dental office 5/2012. The form included, "Instructions for ...(resident's name) and staff" and includued these directions: "You should brush your teeth and rinse your gums after eating for tissue health and to freshen breath." These directions had not been incorporated into the resident's care plan.

R24 was admitted on 11/30/09, with diagnoses that included Alzheimer's, dementia and diabetes mellitus. The annual Minimum Data Set (MDS) dated 4/1/12, indicated R24 required extensive assistance of one person to complete personal hygiene tasks to include brushing teeth.

During an observation on 8/14/13, at 7:37 a.m. R24 was observed to have some teeth missing from the top and bottom of the mouth. R24 was interviewed at the time and stated she had partial dentures for the top and bottom of her mouth. At approximately 8:28 a.m. nursing assistant (NA)-B was observed to have rinsed R24's upper/lower partials and put them in her mouth. Although NA-A rinsed R24's upper/lower partials, R24 was not provided an opportunity to have her remaining natural teeth brushed, nor was the resident offered any other oral hygiene care.

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F 279	Continued From page 19 On 8/14/13 at 8:34 a.m., NA-B confirmed during interview that R24 needed assistance of one to brush teeth twice daily and had upper and lower partials. At 9:43 a.m. NA-B confirmed she did not offer or attempt to brush R24's teeth during her morning care. The director of nursing (DON) stated during interview on 8/14/13, at 12:00 p.m. that R24 could not brush her own teeth and needed extensive assistance of one to help with the task. The facility policy titled Dental Care dated 8/09, directed staff to meet the dental needs of the residents, to ensure quality of life, proper nutrition, dignity, and psychosocial will being. R52's care plan was not developed to identify risk factors, goals, or interventions for diabetic management. R52 was admitted to the facility on 8/1/12, with diagnoses that included: diabetes mellitus (DM), Alzheimers disease and congestive heart failure. R52's annual Minimum Data Set (MDS) dated 7/28/13, indicated R52 required limited assistance for activities of daily living (ADL's) and supervision when independently walking and eating. The MDS identified R52's cognition as severely impaired, the MDS also identified the diagnosis of DM. R52's diabetic physician orders included blood sugar checks twice each day on Monday, Wednesday, Friday and as needed. No blood sugar parameters were indicated. R52 also receive Lantus insulin twice a day.	F 279		

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R52's care plan dated 7/31/13, did not include interventions for staff to follow to meet the resident's diabetic needs, such as guidelines for blood sugar monitoring.

During interview on 8/15/13, at 8:31 a.m. licensed practical nurse (LPN)-B reported staff checked R52's blood sugar on Mondays, Wednesdays and Fridays and as needed. LPN-B reported they gave glucagon (peptide hormone secreted by the pancreas that raises blood glucose levels) to R52 if the blood sugar was low. LPN-B confirmed there were no parameters with the blood sugar results and reported R52's blood sugars usually ran high.

During an interview with RN-B on 8/15/13, at 10:00 a.m., RN-B acknowledged that she had completed the MDS for R52. RN-B confirmed R52 had a diagnosis of DM as indicated on the MDS. RN-B also confirmed no interventions had been developed in R52's care plan for diabetic management.

During interview on 8/15/13, at 10:29 a.m. the DON stated she would not expect her staff to develop a care plan for a resident with a diagnosis of DM. The DON said, "we do not develop care plans for diabetic residents." When the DON was asked how staff were aware of diabetic goals, risk factors, and interventions, she stated staff documented the blood sugars on the medication administration record. The DON also stated green dot stickers were placed on the outside door of a diabetic resident's room. The DON confirmed there were no blood sugar parameters in place for R52.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(X4) ID PREFIX TAG	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 279	Continued From page 21 The facility's policy, Diabetes Mellitus dated 2006, indicated blood sugar parameters needed to be obtained for residents with blood glucose testing. The facility's policy, Care Plan dated 3/12, indicated care plans would ensure resident's had the appropriate care required to maintain or attain the resident's highlest level of practicable function possible.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise and update the care plan for 2 of 4 residents (R58 and R39) in	F 280		

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F 280	Continued From page 22 the sample reviewed for pain; and for 1 of 5 resident (R31) in the sample reviewed for unnecessary medications. Findings include: Although R58 experienced pain, his care plan dated 8/13/13, had not been revised to include interventions to reduce/eliminate the resident's leg pain related to soft tissue and arthritic pain. During an initial interview on 8/12/13, at 5:24 p.m. R58 stated he had intense pain in the right leg when moving the extremity. During the interview R58 was noted to wince and groan with movement of the right leg. R58 stated he had sustained pain in the leg for the past 18 years and the doctor stated it was muscle pain and nothing could be done to resolve the pain. R58 rated his pain at a 9 to 10, on a 0 to 10 scale, with 10 equaling severe pain. Nursing assistant (NA)-A stated on 8/13/13, at 3:00 p.m. R52 complained of pain when staff moved or transferred him, and usually complained of pain with cares. Morning cares were observed on 8/14/13, at 6:37 a.m. after R58 turned on the call light. NA-A removed R58's skid socks by lifting the right leg and pulling the sock off. R58 groaned and winced when staff lifted the right foot to remove sock. When R58's leg was lifted so a clean sock could be put on the right foot, R58 again groaned and winced with pain. NA-A strapped R58 to a standing lift which assisted the resident to stand. Pericare and catheter care were completed while R58 stood. R58 again groaned and winced in pain while standing. R58 was interviewed after	F 280		

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F 280	Continued From page 23 staff completed cares and reported had hurt the right leg 18 years ago and had been to multiple personal doctors, as well as at the Mayo Clinic. R58 stated they had all told him it was muscle pain and was difficult to treat. R58 verified he experienced pain every time when assisted to move or transfer. R58's family member (F)-A was interviewed on 8/14/13, at 11:45 a.m. and stated R58 had ongoing pain for many years related to arthritis in the hip and calf region. F-A further reported R58's physician had informed them the pain was related to bone rubbing bone in the hip region but that R58 was considered too high a risk for surgical intervention. Although R58's admission assessment dated 2/7/13, indicated the resident had no pain, and a quarterly Minimum Data Set (MDS) assessment dated 5/12/13, identified when R58 had been asked about pain over the last five days he'd denied pain each time, an assessment note at the time of the 5/12/13 quarterly MDS noted: "on 11-7's [night shift] resident was identified with moaning with repositioning, and a history of pain in joints, pain in soft tissue, unspecified chest pain." Registered nurse (RN)-B verified on 8/14/13, at 11:20 a.m. R58 had pain in the legs. RN-B explained R58 received routine pain medications for the pain and it was usually associated with mobility of the lower extremities. RN-B verified the care plan lacked any problem, goals, or interventions for R58's pain. An interview on 8/14/13, at approximately 11:40 a.m. the director of nursing services (DON)	F 280		

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F 280	Continued From page 24	F 280		

verified R58 complained about leg pain when staff rolled or turned him in bed. The DON stated R58 had received Physical Therapy (PT) services in the past for pain management. The DON verified there had been no care plan interventions or daily monitoring for pain established by the facility.

An interview was conducted with NA-D on 8/14/13 at 11:48 a.m. NA-D stated she would sometimes work the night shift and care for R58. NA-D stated R58 occasionally had pain at night and noticed he winced and groaned when being repositioned in bed.

The facility policy and procedure, Pain Evaluation and Management dated 2010, identified the following:

"Procedure:
9. Initiate or update care plan to include type of pain, required monitoring including pain management plan and a measurable goal relating to the pain management plan."

R39 had complaints of hand pain and the care plan was not revised to address the pain in her hands when the mechanical lift was used.

R39 had diagnoses that included chronic and generalized pain, and Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 6/24/13, indicated R39 had severely impaired decision making skills and required extensive assistance with all activities of daily living. The MDS indicated R39 had no pain.

On 8/12/13, at 5:03 p.m. R39 was observed

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F 280	Continued From page 25 sitting in a wheelchair with a lap buddy placed over her lap connecting to the wheelchair. R39 was observed restless by picking and tugging at the lap buddy continuously. Observations were conducted on 8/14/13, at 9:26 a.m. of nursing assistant (NA)-E providing morning cares for R39. When NA-E applied lotion to the right hand R39 stated, "ow ow ow my hand." R39 complained again when she grabbed the stand up lift with her hands, and stated, "ow ow ow." On 8/13/13, at 3:59 p.m. NA-D stated was unable to tell if R39 had pain, and stated R39 will sometimes say "ow ow" when lifted with the standing lift. NA-D reported believes the only time R39 had pain was when the stand up lift was used. On 8/14/13, at 7:30 a.m. NA-G stated R39 reported she had pain, NA-G stated R39 would sometimes say "ow" when her hands were put on the stand up lift. On 8/14/13, at 11:22 p.m. registered nurse (RN) -A reported R39 will sometimes verbally say if had any pain. RN-A stated staff monitor for pain everyday, but only document if R39 had pain. RN-A stated the only time a pain assessment was completed was during the MDS period. RN-A reported staff were not providing R39 with any non-pharmalogical interventions at the time because R39's pain was well managed. RN-A stated was not aware of any complaints or symptoms of R39 having pain. On 8/15/13, at 9:25 a.m. NA-E stated did report R39's complaint of pain on 8/14/13, during	F 280		

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F 280	Continued From page 26 morning cares to licensed practical nurse (LPN) -B. The clinical record indicated R39 was receiving Tylenol Extra Strength 1,000 mg (milligrams) twice a day for generalized pain. The current care plan provided by the facility identified the problem of pain was related to a history of a scalp laceration pelvic fracture. The care plan listed the following interventions: administer analgesia as per orders, monitor/record/report to nurse any signs or symptoms of non-verbal pain and to report to nurse any change in usual activity attendance. The quarterly pain assessment, dated 6/24/13, indicated R39 had no verbal or non-verbal signs or symptoms of pain. Although NA-E reported R39 had complaints of pain to LPN-B on 8/14/13, there was no indication in the progress notes (reviewed from 5/22/13 to 8/15/13), regarding R39 having any pain. On 8/14/13, at 12:06 p.m. registered nurse (RN) -B confirmed there was no current indication of why R39 was having pain, RN-B also confirmed there were no non-pharmalogical interventions on R39's pain care plan. RN-B stated staff updates care plan quarterly and as new issues arise. On 8/15/13, at 7:50 a.m. the DNS confirmed R39's care plan should include the current indication of pain, not only the history of residents pain origination. The DNS also confirmed non-pharmalogical interventions should be on pain care plan. Reviewed the Volunteers of America Care Plan	F 280		

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F 280	Continued From page 27 Policy and Procedure dated 3/12, indicated the care plan was changed and updated as the care changes for the resident and as the resident changes and was to be current at all times. Review of R31's care plan dated 3/25/13, indicated the resident had behaviors related to being verbally abusive to staff at times, making negative comments, and isolating self in room. The behaviors described in the care plan had not been revised to reflect behaviors including delusions of other residents entering her room and taking things, as identified during interview with the social services director (SSD) and quality coordinator. R31 was interviewed on 8/12/13, at 7:41 p.m. while she was in her room. The resident was observed to remain calm during the entire interview. During subsequent observations at 10:36 a.m. on 8/14/13, at 12:50 p.m. on 8/14/13, and again at 8:15 a.m. on 8/15/13, the resident continued to demonstrate a calm demeanor. R31's record was reviewed. According to the	F 280		

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F 280	Continued From page 28 record, R31 received Risperdal (an antipsychotic) 0.5 milligrams (mg) twice daily (BID) for dementia with delusions. The resident was also receiving Zoloft which had been increased 125 mg in May of 2013. The facility's consultant pharmacist had made a recommendation on 3/16/13, to reduce the Risperdal to 0.25 mg BID, and on 8/7/13 had made another recommendation which suggested staff should hold the Risperdal. The record indicated R31 had been admitted to the facility in August of 2011 with diagnoses that included depression and dementia with delusions. The Minimum Data Set (MDS) dated 7/28/13 identified the resident as being cognitively impaired, as having experienced feeling down and depressed in the past 7-11 days, and indicated the resident's behavior had improved with no inappropriate behaviors displayed. The SSD was interviewed on 8/14/13, at 11:00 a.m. and stated R31 would demonstrate behaviors such as accusing other residents of coming into her room when they had not been in her room, and would pinpoint different residents and say they were moving things around in her room. In addition, the SSD said the resident made those types of allegations about persons who did not even reside at the facility. During interview on 8/14/13 at 12:47 p.m., the quality coordinator also stated the resident had behaviors and delusions such as making accusations that residents were going into her room and taking her personal belongings. The quality coordinator verified that no residents have been seen in the resident's room nor has she had any missing items. The quality coordinator also verified the facility's behavior monitoring logs did	F 280		

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F 280	Continued From page 29 not capture the actual behaviors the resident was experiencing, because the logs indicated there had been no behaviors noted, and this behavior had not been included in the resident's plan of care.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow their policy to develop a care plan for pain management and failed to conduct ongoing assessment to identify pain indicators to identify interventions that could be utilized to minimize pain and enhance quality of life for 2 of 4 residents (R58 and R39) reviewed for pain. Findings include: R58 had chronic long term pain in the right leg that was not adequately managed to decrease or minimize the discomfort. During an interview on 8/12/13, at 5:24 p.m. R58 reported intense pain in the right leg when moving the extremity. During the interview R58 was noted to wince and groan with movement of the right	F 309		

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F 309	Continued From page 30 leg. R58 stated he had sustained pain in the leg for the past 18 years and the doctor stated it was muscle pain and nothing could be done to resolve the pain. R58 rated the pain between a 9 and 10, with 10 representing excruciating pain. Nursing assistant (NA)-A stated on 8/13/13, at 3:00 p.m. R52 complained of pain when staff moved or transferred him, and usually complained of pain with cares. Morning cares were observed on 8/14/13, at 6:37 a.m. after R58 turned on the call light. NA-A removed R58's skid socks by lifting the right leg and pulling the sock off. R58 groaned and winced when staff lifted the right foot to remove sock. When R58's leg was lifted so a clean sock could be put on the right foot, R58 again groaned and winced with pain. NA-A strapped R58 to a standing lift which assisted the resident to stand. Pericare and catheter care were completed while R58 stood. R58 again groaned and winced in pain while standing. R58 was interviewed immediately after staff had completed cares, and reported he'd had hurt the right leg 18 years ago and had been to multiple personal doctors, as well as to the Mayo Clinic for care. R58 stated they had all told him it was muscle pain and was difficult to treat. R58 verified he experienced pain every time he was assisted to move or transfer. R58's family member (F)-A was interviewed on 8/14/13, at 11:45 a.m. and stated R58 had ongoing pain for many years related to arthritis in the hip and calf region. F-A further reported R58's physician had informed them the pain was related to bone rubbing bone in the hip region and R58 was considered too high of risk for surgical intervention.	F 309		

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F 309	Continued From page 31 R58's admission assessment dated 2/7/13, noted the resident had no pain. A quarterly Minimum Data Set (MDS) assessment dated 5/12/13, identified when R58 was asked about pain over the last five days he denied pain each time. "On one note on 11-7's [night shift] resident was identified with moaning with repositioning. and a history of pain Pina in joints, pain in soft tissue, unspecified chest pain." R58's care plan dated 8/13/13, failed to identify the presence of long term soft tissue and arthritic pain in the resident's leg, with goals and interventions to minimize the risk of pain. Registered nurse (RN)-B verified on 8/14/13, at 11:20 a.m. R58 had pain in the legs. RN-B explained R58 received routine pain medications for the pain and it was usually associated with mobility of the lower extremities. RN-B verified the care plan lacked any problem, goals, or interventions for R58's pain. An interview on 8/14/13, at approximately 11:40 a.m. the director of nursing (DON) verified R58 complained about leg pain when staff rolled or turned him in bed. The DON stated R58 had received Physical Therapy (PT) services in the past for pain management. The DON further stated it was not the facility policy to develop a care plan for pain and identified R58 could vocalize if had any pain. The DON verified there was no care planning or daily monitoring of pain provided by the facility. An interview was conducted with NA-D on 8/14/13 at 11:48 a.m. who was working as the trained medication aide (TMA) on R58's hall.	F 309		

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F 309	Continued From page 32 NA-D verified R58 had no daily pain monitoring indicated in the medication administration record (MAR). NA-D stated would sometimes work the night shift and care for R58. NA-D stated R58 occasionally had pain on nights and noticed he winced and groaned when being repositioned in bed. R39 had chronic/generalized pain. R39's pain was not adequately managed to decrease or minimize the discomfort when complaining of hand pain when the stand up lift was used. R39 had diagnoses that included chronic and generalized pain and Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 6/24/13, indicated R39 had severely impaired decision making skills and required extensive assistance with all activities of daily living. The MDS indicated R58 had no pain. On 8/12/13, at 5:03 p.m. R39 was observed sitting in a wheelchair with a lap buddy placed over her lap connecting to the wheelchair. R39 was observed restless by picking and tugging at the lap buddy continuously. Observations were conducted on 8/14/13, at 9:26 a.m. of nursing assistant (NA)-E providing morning cares for R39. When NA-E applied lotion to the right hand R39 stated, "ow ow ow my hand." R39 complained again when she grabbed the stand up lift with her hands, and stated, "ow ow ow." On 8/13/13, at 3:59 p.m. NA-D stated was unable	F 309		

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F 309	Continued From page 33	F 309		

to tell if R39 had pain, and stated R39 will sometimes say "ow ow" when lifted with the standing lift. NA-D reported believes the only time R39 had pain was when the stand up lift was used.

On 8/14/13, at 7:30 a.m. NA-G stated R39 reported she had pain, NA-G stated R39 would sometimes say "ow" when her hands were put on the stand up lift.

On 8/14/13, at 11:22 p.m. registered nurse (RN) -A reported R39 will sometimes verbally say if had any pain. RN-A stated staff monitor for pain everyday, but only document if R39 had pain. RN-A stated the only time a pain assessment was completed was during the MDS period. RN-A reported staff were not providing R39 with any non-pharmalogical interventions at the time because R39's pain was well managed. RN-A stated was not aware of any complaints or symptoms of R39 having pain.

On 8/15/13, at 9:25 a.m. NA-E stated did report R39's complaint of pain on 8/14/13, during morning cares to licensed practical nurse (LPN) -B.

The clinical record indicated R39 was receiving Tylenol Extra Strength 1,000 mg (milligrams) twice a day for generalized pain. The current care plan provided by the facility identified the problem of pain was related to a history of a scalp laceration pelvic fracture. The care plan listed the following interventions: administer analgesia as per orders, monitor/record/report to nurse any signs or symptoms of non-verbal pain and to report to nurse any change in usual activity attendance.

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	245225	A. BUILDING ______ B. WING ______	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(X4) ID PREFIX TAG	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
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The quarterly pain assessment dated 6/24/13, indicated R39 had no verbal or non-verbal signs or symptoms of pain.

Although NA-E reported R39 had complaints of pain to LPN-B on 8/14/13, there was no indication in the progress notes (reviewed from 5/22/13 to 8/15/13), regarding R39 having any pain.

On 8/15/13, at 7:50 a.m., the DON verified nursing assistants were expected to report resident's pain to the nurse, and once the charge nurse was updated pain sheets were put on the MAR to monitor for pain. The DON confirmed LPN-B did not document R39's pain on 8/14/13, was not in the progress notes.

The facility policy and procedure for pain, Pain Evaluation and Management, dated 2010 identified the following:

"Policy: It is the policy for Volunteers of America (VOA) that all residents have the right for appropriate pain assessment and management. All residents will be evaluated for indicators or a history of pain for the MDS 3.0 on admission, quarterly, with significant change in status, and with the new onset of potential pain or discomfort. Data will be collected through resident interviews, staff interviews and observations.

Procedure:
1. With and MDS scheduled assessments, data is collected related to resident's potential indicators. If the resident is experiencing unrelieved pain, refer to the interdisciplinary team.

6. If the resident has a diagnosis which could

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F 309	Continued From page 35 cause pain or discomfort, and they show no sign or symptoms of pain or discomfort, continue to reassess for indicators of pain and behavioral changes. 7. Notify MD of pain assessment findings if pain is indicated to start or change pain management program as necessary with ongoing evaluation of effectiveness of medications prescribed. 9. Initiate or update care plan to include type of pain, required monitoring including pain management plan and a measurable goal relating to the pain management plan. 10. Review pain assessment quarterly and as needed. Note any changes or revisions in current plan. highlight any areas no longer applicable."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate oral hygiene for 1 of 1 resident (R24) initiated for review due to dependence on staff for oral/dental hygiene care. Findings include:	F 312		

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F 312	Continued From page 36 During an observation on 8/14/13, at 7:37 a.m. R24 was observed to have some teeth missing from the top and bottom of the mouth. R24 was interviewed at the time and stated she had partial dentures for the top and bottom of her mouth. At approximately 8:28 a.m. nursing assistant (NA)-B was observed to have rinsed R24's upper/lower partials and put them in her mouth. Although NA-A rinsed R24's upper/lower partials, R24 was not provided an opportunity to have her remaining natural teeth brushed, nor was the resident offered any other oral hygiene care. On 8/14/13 at 8:34 a.m., NA-B confirmed during interview that R24 needed assistance of one to brush teeth twice daily and had upper and lower partials. At 9:43 a.m. NA-B confirmed she did not offer or attempt to brush R24's teeth during her morning care. R24 was admitted on 11/30/09, with diagnoses that included Alzheimer's, dementia and diabetes mellitus. The annual Minimum Data Set (MDS) dated 4/1/12, indicated R24 required extensive assistance of one person to complete personal hygiene tasks to include brushing teeth. R24's care plan last revised 5/19/13, indicated R24 needed physical assistance of one with personal hygiene care, but did not include specific directions for oral/dental care. Care of the resident's partial dentures had also been documented on the dental referral form from the dental office 5/12. The form included, "Instructions for ...(resident's name) and staff" and includued these directions: "You should brush your teeth and rinse your gums after eating for tissue health and to freshen breath." The director of nursing (DON) stated during	F 312		

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F 312	Continued From page 37 interview on 8/14/13, at 12:00 p.m. that R24 could not brush her own teeth and needed extensive assistance of one to help with the task. The facility policy titled Dental Care dated 8/09, directed staff to meet the dental needs of the residents, to ensure quality of life, proper nutrition, dignity, and psychosocial well being.	F 312		
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	F 329		

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F 329	Continued From page 38 by: Based on observation, interview and document review, the facility failed to adequately monitor clinical indications for continued use of medications and to accurately document and report findings to the medical provider for 1 of 5 residents (R31) in the sample whose medications were reviewed. Findings include: R5 had recommended revisions to her medication regime. The resident was utilizing an antidepressant (Zoloft) and an antipsychotic (Respiridone also referred to as Risperdal). Although the resident was routinely receiving psychiatric consultative care, the nursing staff had not routinely provided the psychiatric provider with monitoring documentation for review to ensure he had current behavioral information to determine efficacy and implementation of medication use. R31 was interviewed on 8/12/13, at 7:41 p.m. while she was in her room. The resident was observed to remain calm during the entire interview. During subsequent observations at 10:36 a.m. on 8/14/13, at 12:50 p.m. on 8/14/13, and again at 8:15 a.m. on 8/15/13, the resident continued to demonstrate a calm demeanor. R31's record was reviewed. According to the record, R31 received Risperdal (an antipsychotic) 0.5 milligrams (mg) twice daily (BID) for dementia with delusions. The resident was also receiving Zoloft which had been increased 125 mg in May of 2013. The facility's consultant pharmacist had made a recommendation on 3/16/13, to reduce the Risperdal to 0.25 mg BID, and on 8/7/13 had	F 329		

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F 329	Continued From page 39 made another recommendation which suggested staff should hold the Risperdal. The record indicated R31 had been admitted to the facility in August of 2011 with diagnoses that included depression and dementia with delusions. The Minimum Data Set (MDS) dated 7/28/13 identified the resident as being cognitively impaired, as having experienced feeling down and depressed in the past 7-11 days, and indicated the resident's behavior had improved with no inappropriate behaviors displayed. The social service director (SSD) was interviewed on 8/14/13, at 11:00 a.m. and stated R31 would demonstrate behaviors such as accusing other residents of coming into her room when they had not been in her room, and would pinpoint different residents and say they were moving things around in her room. In addition, the SSD said the resident made those types of allegations about persons who did not even reside at the facility. During interview on 8/14/13 at 12:47 p.m., the quality coordinator also stated the resident had behaviors and delusions such as making accusations that residents were going into her room and taking her personal belongings. The quality coordinator verified that no residents have been seen in the resident's room nor has she had any missing items. The quality coordinator also verified the facility's behavior monitoring logs did not capture the actual behaviors the resident was experiencing, because the logs indicated there had been no behaviors noted. The quality coordinator verified there had been no attempts at a gradual dose reduction or discontinuance of the Risperdal.	F 329		

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F 329	Continued From page 40 Review of R31's care plan dated 3/25/13, indicated the resident had behaviors related to being verbally abusive to staff at times, making negative comments, and isolating self in room. The behaviors described in the care plan did not reflect the behaviors of delusions of other residents entering her room and taking things, as identified during interview with the SSD and quality coordinator. The care plan indicated the facility staff were supposed to consult with pharmacy, and the medical doctor to consider a dosage reduction when clinically appropriate. In addition the care plan indicated the staff were supposed to monitor and document behaviors. Documented nursing notes were reviewed. The most recent notation about the resident's behavior of delusions of other's entering her room was from 3/26/13. Progress notes in the record indicated the resident had been receiving psychiatric follow up from a psychologist who visited her at the facility, and more recently from a psychiatric telecare physician. The telecare physician utilized video conferencing type consultative features to evaluate the resident from distant site location in another state. The telecare psychiatrist had responded to the pharmacist recommendations for reduction to the Risperdal on 7/10/13, indicating "no change to plan of care". The psychiatrist orders dated 5/30/13 had also indicated to increase the Zoloft to 125 mg and to continue the Risperdal 0.5 mg BID. Other interventions included encouraging R31 to leave her room and participate in activities, and reassuring R31 her room will be observed when she leaves so she doesn't feel compelled to stay in her room. The orders indicated the telecare psychiatrist wanted a follow up in 6 weeks.	F 329		

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F 329	Continued From page 41 During interview the interview with the quality coordinator on 8/14/13 at 12:47 p.m., the quality coordinator verified neither the telecare psychiatrist nor the resident's primary physician had reviewed the behavior monitoring logs to see there had been no documented behaviors, but instead care decisions were based off the information that was verbalized to them by staff and the resident. The facility's Daily Target/Mood/Behavior Observation Tool Policy, indicated the purpose was so "residents identified on psychotropic medications and/or targeted behaviors will be monitored on a daily basis. Ongoing log will be retained identifying target behaviors, interventions, outcomes of intervention, and frequency of behaviors exhibited. In addition, members of the care team are to complete the daily behavior observation form and document when a resident exhibits mood and behaviors, with communication to the licensed nurse and/or social worker as appropriate."	F 329		
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 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).	F 356		

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F 356	Continued From page 42 - 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 include the actual hours worked by discipline on the required nurse staffing information, which had the potential to affect all 42 residents who resided in the facility and any public visitors who wished to review the facility's staffing patterns. Findings include: During the environmental tour on 8/15/13, at 10:45 a.m. the required posting of nurse staffing information was observed posted on a wally in the hallway however, the posting did not include the actual number of hours worked by discipline (ie., registered nurse, licensed practical nurse, nursing assistant). Postings from 8/6/13 to 8/14/13 were	F 356		

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F 356	Continued From page 43 requested for review. It was noted these postings also failed to include a total of the actual hours worked by each nursing discipline. During interview on 8/15/13, at 3:52 p.m. the director of nursing (DON) reported that she was responsible for the posting of nursing hours each day. The DON confirmed that the nurse staffing postings did not include the actual hours worked for each discipline. Review of the facility's untitled and undated policy indicated actual hours worked must be included in the nurse staffing posting.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sanitary conditions related to cleaning of kitchen equipment; and failed to minimize the possibility of foodborne illness by ensuring outdated food products were unavailable for use. These deficient practices had the potential to affect all 42 residents residing in the facility.	F 371		

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F 371	Continued From page 44	F 371		

Findings include:

A kitchen tour was completed on 8/12/13, at 2:43 p.m. The meat slicer blade had dried food debris on an area approximately 1 inch by 0.25 inch. The meat slicer tray area also had two areas of dried food debris measuring approximately 0.2 centimeter (cm) x 0.2 cm. The dietary manager stated the meat slicer was used weekly and the debris appeared to be roast beef.

The refrigerator in the kitchen contained one half gallon of opened 100% lactose free milk with not date as to when it had been opened. A 24 ounce (oz.) container of chocolate syrup was also observed to have been opened and available for use. The syrup also had no date written on it to indicate when it had been opened. The dietary manager confirmed staff were supposed to date containers as to when they'd been opened.

The medication room refrigerator contained nine thawed 16 ounce (oz) maple nut flavored Kemps Plus 2 nutritional supplements with no date when they'd been taken out of the freezer. The dietary manager stated it was unknown when the supplements had been taken out of the freezer and put into the refrigerator. The medication refrigerator also contained one opened 46 oz thickened cranberry juice cocktail liquid with no written date when it had been opened.

During an interview with the director of nurses (DON) on 8/15/13, at 10:35 a.m., the DON stated the nursing staff were aware they were to label and date any beverages or food they opened, indicating when the items had been opened.

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F 371	Continued From page 45 A registered nurse (RN)-A stated on 8/15/13, at 10:56 a.m. that once the supplements were pulled from the freezer they were good for 10 days in the refrigerator. RN-A stated the kitchen dated the cases when the supplements were pulled from the freezer. During an interview with licensed practical nurse (LPN)-A on 8/15/13, at 11:00 a.m., LPN-A stated the staff would not know when the supplements were pulled from the freezer if they did not remain in the case. LPN-A stated that supplements were removed from the dated cases to make room in the medication refrigerator for other items. During an observation of the medication room refrigerator on 8/15/13 at 11:05 a.m., there were nine thawed 16 oz Kemps Plus 2 supplements available for use. These supplements were undated, and were not in a dated case. LPN-A stated that staff were supposed to have left the supplements in the dated cases, but didn't always do that. The facility policy, Food Storage dated 2010, indicated that all foods were to be covered, labeled, and dated. The policy also indicated date marking was to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold, or discarded. The policy indicated the date mark was to be visible on all high risk foods.	F 371		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		

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F 465	Continued From page 46 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 resident room hallways (north hallway) was free from pervasive urine odors. This had the potential to affect all residents who resided in the north hallway and any visitors traveling that hall. Findings include: During observations of R28's room on 8/12/13, at 6:12 p.m., a strong urine odor permeated into the hallway where other residents, visitors and staff members were located. The smell of urine lingered approximately 50 feet out into the hallway. On 8/13/13, at 3:12 p.m., R28's room continued to have the same pungent urine odor, and the odor extended out into the hallway. On 8/14/13 at 6:50 a.m., the same pungent odor was noted in R28's room and in the entire hallway adjacent to R28's room. Although no residents complained of the odor, on 8/14/13 at 1:57 p.m., nursing assistant (NA)-B was interviewed and stated R28's room "always has an odor of urine." At 2:03 p.m. on 8/14/13, licensed practical nurse (LPN)-B also stated R28's room "always smell of urine." On 8/15/13 at 9:40 a.m., the director of nursing (DON) confirmed R28's room had a strong urine smell permeating into the hallway and stated, "it	F 465		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING ______ B. WING ______	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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F 465	Continued From page 47 should be cleaned daily." The DON indicated she would expect R28's room to be free of odors. On 8/15/13 at 12:10 p.m., social services (SS) staff-A confirmed R28's room had a strong urine odor present. The facility's 2013 policy, Infection Control Environmental Services/ Housekeeping and Laundry, specified that a clean, safe and sanitary environment was to be maintained for residents. The policy also specified the workplace will be maintained in a clean and sanitary condition.	F 465		

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Sleepy Eye Care Center
1105 3rd Ave SW
Sleepy Eye, MN 56085
Provider ID # 245225

Plan Of Correction For CMS-2567

K 056

We dismantled the 52" pallet racking sections that were blocking the sprinkler head and cut them down to 28" and reassembled a double shelf racking. This gives the sprinkler head 48" clearance to the racking

Director of Environmental Services is responsible for overall compliance.

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	245225	A. BUILDING 01 - SLEEPY EYE CARE CENTER B. WING	08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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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 REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 16, 2013. At the time of this survey, Sleepy Eye 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	RECEIVED SEP 18 2013 Minnesota Department of Health Marshall	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela Adams
TITLE: Administrator
(X6) DATE: 9/17/2013

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 By E-Mail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Sleepy Eye Care Center was constructed as follows: The original building was constructed in 1972, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II (000) construction; A building addition was constructed in 1985, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 46 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101-2000 edition, Section 19.3.5 and 9.7;NFPA 13-1999 edition, Section 5-1.1. This deficient practice could affect 10 out of 42 residents. Findings include: On facility tour between the hours of 12:00 PM and 3:00 PM on 8/16/2013, observation revealed that the boiler room maintenance office has a 4ft. by 15ft. shelf extending from wall to wall with storage supplies underneath that did not have sprinkler protection.	K 056		

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K 056	Continued From page 3 This deficient practice was confirmed by the Plant Engineer at the time of discovery.	K 056		

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

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