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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FY3O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00048

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **695045102**

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

4. TYPE OF ACTION: **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 **07/31/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Chris Campbell, Unit Supervisor 09/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/29/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245045

September 25, 2015

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

Dear Mr. Breuer:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 19, 2015 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 3, 2015

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

RE: Project Number S5045025

Dear Mr. Breuer:

On June 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 8, 2015. 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 July 31, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 10, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 19, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 8, 2015, effective July 19, 2015 and therefore remedies outlined in our letter to you dated June 22, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245045	A. Building B. Wing	7/31/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/19/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **07/19/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **07/19/2015**
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 CC/mm	Date: 08/03/2015	Signature of Surveyor: 13922	Date: 07/31/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/8/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245045	A. Building / B. Wing: 01 - MAIN BUILDING	7/10/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	06/11/2015	ID Prefix Reg. # NFPA 101 LSC K0038	06/30/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	08/03/2015	03005	07/10/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/3/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FY3O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00048

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **695045102**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/08/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Cynthia Stramel, HFE NEII 07/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/28/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 6015

June 22, 2015

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

RE: Project Number S5045025

Dear Mr. Breuer:

On June 8, 2015, 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 19, 2015, 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 July 19, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 8, 2015 (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 December 8, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING _____ B. WING _____	06/08/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care and services were assessed and provided to minimize the risk of falls for 1 of 2 residents (R20) reviewed for accidents. Findings include: R20 had several falls since admission on 1/12/15. The facility determined R20 had a decline in	F 323	SHCC does ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This deficiency was noted on 1 of 2 residents. The deficiency relates specifically to R20. R20's current fall interventions were	7/19/15

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

Electronically Signed | 07/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING _____ B. WING _____	06/08/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 cognition and failed to assess ways to assist R20 with vulnerabilities increasing his fall risk such as impulsiveness and safety awareness or assisting R20 to develop skills to transfer more safely. R20's Cumulative Diagnosis List dated 1/12/15, indicated R20's diagnoses included right sided hemorrhagic cerebral vascular accident (CVA/stroke) with left sided weakness and sensation loss, cramps of limbs, depression, factor five Leiden deficiency (inherited disorder of blood clotting), and a history of pulmonary embolism with long term Coumadin (blood thinner) use. The quarterly Minimum Data Set (MDS) assessment dated 4/15/15, indicated R20 had no cognitive impairment, behaviors or rejection of cares. R20 required the extensive assistance of two staff with bed mobility, transfers and toilet use. R20 was frequently incontinent of urine but continent of bowel. R20 had previous falls with injuries that were not significant. An admission Fall Risk Assessment dated 1/12/15, indicated R20 denied having any falls prior to the CVA and understood she was at risk for falls due to left sided weakness. The assessment further indicated R20 was alert and orientated and used the call light appropriately to call for staff assistance. The Care Area Assessment (CAA), dated 1/21/15, indicated R20 was art risk for falls. R20 had loss of sensation on the left side which did inhibit her at times. R20 was incontinent of urine, was aware of toileting needs, however had urine loss on the way to the bathroom. R20 is offered to use the toilet every two hours and as needed and	F 323	reviewed at the IDT meeting and changes were made to her plan of care. Occupational, Physical, and Speech therapy will be re-assessing transfer ability and cognition. Due to residents decline in cognition, a significant change has been scheduled. The IDT has reviewed all residents related to their specific fall interventions and accident hazards. Measures to correct the deficient practice are as follows: SHCC will put in to place the following interventions to protect residents with similar situations by having fall reports sent to the Risk/Compliance Officer immediately for review. The RN Manager will bring a copy of the incident report along with the resident's plan of care to the daily meeting so the IDT can review and discuss current interventions and revise/change immediately. Fall reports will be discussed at the end of the meeting in order to provide time and focus for each situation. QA review will be conducted on all fall reports weekly for 3 months to ensure appropriate interventions are in place. The DON and Nurse Managers will be responsible. Findings will be discussed at the quarterly LTC QA meeting to determine if changes or revisions are needed immediately.	

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will use the call light to inform staff. R20 has limitations in range of motion (ROM) on the left side from the CVA. R20 was working with physical therapy (PT), occupational therapy (OT) and speech therapy (ST) toward independence. R20 had one fall since admission when her foot slipped on the affected side. R20 does not attempt to self transfer. R20 remained on Coumadin and is at risk for bleeding.

The Fall Prevention care plan initiated 1/13/15 and updated on 5/11/15 indicated R20 was at risk for falls due to a CVA. R20 was very impulsive and would transfer multiple times without asking for help and needed constant reminders from staff. Other risk factors included poor safety awareness, CVA with left sided weakness, blood pressure medications, Coumadin use, unsteady gait and balance and laxative use. Fall prevention interventions included; nonskid material added to the floor by the bedside, toilet and to the grab bar in the bathroom. Shoes on for all transfers. Staff was directed to toilet and offer assistance for bed at 7:00 p.m.

The following information was gathered from incident reports for R20's falls since admission on 1/12/15:

On 1/13/15, at 6:15 a.m. R20 was lowered to the floor by a nursing assistant (NA). R20's foot slipped while transferring onto the toilet. R20 was wearing gripper socks. The intervention was R20 would wear shoes for all transfers.

On 2/18/15, at 6:45 p.m. staff heard R20 yelling "help me" from her room. R20 was found on the floor on her left side. R20 stated a visitor wheeled her into her room and stood by while she

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transferred herself. After the visitor left the room R20 was sitting on the edge of the bed when she slid off and then onto her left side.
A Post Fall Assessment dated 2/19/15, indicated R20 had one fall since admission, related to being fairly new and R20 and staff becoming familiar. R20 was to wear shoes for all transfers and have the assistance of two for transfers. The Post Fall summary included R20 was aware to call for assistance with transfers and discussed the need to ask for assistance with transfers. R20 stated she understood. The summary further indicated R20 was alert and orientated, had no alarms in place and would use the call light for transfer assistance. After a long discussion R20 stated she felt it would not happen again.

On 4/7/15, at 7:15 p.m. R20 again fell in the bathroom. R20 was found sitting on the floor on her buttocks with her back against the wall. R20 reported self transferring from bed to the wheelchair then to the toilet. R20 reported she used her left hand (weaker side) to try and hold the grab bar. R20 was offered toileting by staff at 5:05 p.m. R20 reported she did not need to use the toilet and agreed 7:00 p.m. would be a good time for staff to assist with toileting and evening cares. R20 stated she had waited for awhile but staff reported her room call light was not on and her bathroom light was on only for a short period of time. R20's roommate had also put her call light on.
A Post fall assessment dated 4/7/15 indicated this was the third fall since admission. R20 has had a slow decline in condition, was impulsive at times and attempted tasks that are not safe independently. R20 required staff assistance for transfers and ambulation due to left sided weakness. Additional interventions included staff

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was to toilet and offer assistance to get ready for bed at 7:00 p.m. R20 stated she was holding onto the grab bar in the bathroom with her effected extremity and tried to pull up her pants with her right hand and her left hand let go.

On 5/3/15, at 10:30 a.m. R20's call light was on and R20 was found sitting on the floor in the bathroom with her back against the wall and her legs extended in front of her. R20 reported she had stomach cramps and had to get to the bathroom immediately. The NA reported cares were just done at 10:15 a.m. and R20 was in the bathroom at that time.
A Post fall assessment dated 5/4/15, indicated this was R20's fourth fall since admission. Two were in morning and two were in the evening. This appeared to be an isolated incident, no further safety interventions were implemented. The NA was present at 10:15 a.m. and had just finished cares in the bathroom. R20 reported she needed to have a bowel movement(BM) immediately and could not wait. R20 transferred herself onto the toilet, had a BM and attempted to transfer herself back into the w/c and was unable to pivot her foot and slid down the wall. R20 was again educated on the importance of waiting for staff assistance with transfers and toileting. R20 continues to be impulsive with poor safety awareness, R20 has had multiple fall related to self transferring. Staff continues to encourage R20 to wait for assistance. Cognitively R20 is able to make her needs known but does have some periods of forgetfulness.

On 6/3/15, at 11:32 a.m. R20 stated she has put on the call light and has to wait up to 45 minutes for help. R20 stated she has fallen in the bathroom because she has had to toilet herself.

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F 323	Continued From page 5 R20 stated she uses her left hand (weaker side) to hold the bar and uses the right hand to pull up her pants. She's unable to hold onto the bar with the weaker hand and has fallen. R20 stated she checks her watch when she puts the call light on and when they show up so she knows the amount of time she has to wait. On 6/4/15, at 6:40 p.m. nursing assistant (NA)-A offered to assist R20 to the bathroom. The NA called for transfer assist. The NAs assisted R20 to the edge of the bed, stood and turned R20 into the wheelchair. R20 stood holding onto the transfer bar and the assistance of the two NAs. NA-A lowed R20's pants and brief and R20 sat on the toilet. On 6/4/15, at 6:45 p.m. NA-A stated R20 required two staff to transfer in and out of bed and one staff to transfer on and off the toilet. On 6/8/15, at 9:25 a.m. registered nurse (RN)-B, stated R20 was to be toileted every two hour and per her request. RN-B also stated R20 has had a decline in her cognition. The facility's Fall Prevention policy revised on 3/12/09, indicated the purpose was to reduce or eliminate falls and the consequences related to falls. To protect residents and promote resident safety. To honor the resident's wishes or desires for maximum independence and mobility.	F 323		
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.	F 356		7/19/15

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F 356	Continued From page 6 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). - 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 ensure the nurse posting was accurate regarding the actual number of licensed staff on duty for 2 of 2 days reviewed. This had the potential to affect all 42 residents residing in the facility as well as visitors who may wish to view this information. Findings include:	F 356	SHCC does post Nurse Staffing information on a daily basis. F 356 was corrected by including the actual total hours worked per shift on the facility¿s Nurse Staff Posting. The Nurse Staff Posting will be visible for all residents and families to observe. Measures to correct the deficient practice	

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F 356	Continued From page 7 During the initial facility tour on 6/4/15, at 2:45 p.m. the nursing staff positing hours were observed in a gray file folder attached to the wall, directly across from the elevator. The nurse staff posting had to be removed from the wall file folder to be observed. The posted nursing staff information was dated 6/3/15, and lacked a consistent recording of the actual hours worked per shift by licensed and unlicensed staff responsible for resident care. On 6/4/15, at 12:20 p.m. the staffing coordinator confirmed the nurse staff postings lacked the actual hours worked for shifts and short shifts. Review of the forms from 6/4/15-6/6/15 lacked the actual hours worked. The staffing coordinator verified she is responsible for updating the nursing staff posting and has not indicated the actual hours worked on any of the postings. On 6/5/15, at 12:30 p.m. the director of nursing (DON) confirmed the nursing staff posting lacked the actual hours worked by licensed and unlicensed staff. The facility's Posting Direct Care Daily Staffing Number policy (undated), indicated the posting should include the actual time worked during that shift for each category and type of nursing staff.	F 356	are as follows; the Nursing Staff Posting will have the actual hours worked per shift by licensed and unlicensed staff responsible for resident care. An RN will be designated to ensure actual hours worked are correct at the beginning of each shift; education will be provided. Monitoring will be done weekly for one month, and then every other week for one month and then monthly for one month to assure the Nurse Staffing Information is posted correctly. The correction will be monitored by the DON to ensure compliance. Monthly- Issues will be brought to the Resident Care Team meeting with results of audits by the DON. Results will be provided at the quarterly LTC QA meeting. The Posted Nurse Staffing Information policy was updated and revised. The DON will be responsible.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425		7/19/15

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F 425	Continued From page 8 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure a medication was available for 1 of 7 (R41) residents observed during medication administration. Findings include: On 6/5/15 at 12:57, licensed practical nurse (LPN)-A was observed preparing medications for R41. The LPN indicated the resident's calcium carbonate (a dietary supplement) was out, so she was unable to give the medication. A physician order dated 11/11/13 was for calcium carbonate 500 milligrams, two times daily. Review of the resident's medication administration record (MAR) indicated the calcium carbonate had not been given on 6/4 in the afternoon, 6/3 both doses, 6/2 both doses,	F 425	SHCC does provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. The deficiency was noted on 1 out of 7 residents. R41 was corrected by ordering the calcium carbonate immediately from the Pharmacy. MD was notified regarding missed doses. All residents with reason code "not available" were reviewed to ensure other residents are not impacted by this deficient practice. Measures to correct the deficient practice	

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F 425	Continued From page 9 6/1 afternoon dose, 5/31 afternoon dose, 5/30 both doses and 5/29 afternoon dose. The calcium carbonate was documented as given on 5/31, 6/1 and 6/4/15 in the morning by LPN-B. Interview with the director of nursing (DON) on 6/5/15 at 1:33 p.m. indicated when a medication had approximately seven days of supply left, the sticker should be removed and faxed to the pharmacy for reorder. The calcium carbonate had not been reordered; the pharmacy did not have a refill order for it. The DON also stated LPN-B signed out the calcium carbonate as administered. The DON added LPN-B should not have signed the medications out as they had not been dispensed. The Pharmacy Communication Guide dated July 2014, indicated refills were obtained by peeling the re-order label off the prescription label, affix the label to a re-order form and fax to the pharmacy when there was approximately a five day supply remaining.	F 425	are as follows: The reason code "not available" will be inactivated from the computer dictionary. Licensed nursing staff will be in-serviced on proper documentation for administered and/or non-administered medication. The Pharmacy Communication Guide will be reviewed with all Licensed staff to ensure re-ordering of medications is occurring in a timely manner. Monitoring will be conducted by a computer generated audit that is able to track all medications charted as "non-administered". Audits will be conducted weekly for 3 months to ensure compliance. The DON and Nurse Managers will be responsible. Findings will be discussed at the monthly Nurses meeting to determine if changes or revisions are needed immediately. Findings will be discussed at the quarterly LTC QA meeting to determine if changes or revisions are needed immediately. Medication Administration Policies will be updated and revised.	

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	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/03/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Sunnyside Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST PAUL, MN 55101-5145 and,	K 000	EPOC	

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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: 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 Sunnyside Care Center, is a 3-story building with no basement. The original building was constructed in 1962 and was determined to be of Type II(111) construction. In 1968 the second floor was added, aslo Type II(111) construction. In 2000 dining rooms were constructed on floors one and two of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. This skilled nursing home is not 2 hour fire rated sparated from the attached hospital, and the hospital was also inspected. The nursing home beds are all locatted on the 2 story of the building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas	K 000		

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K 000	Continued From page 2 have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 44 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect all of the buildings occupants. . Findings include: During facility tour on 6-3-15 between 8:00-10:00AM, observation revealed that room 225 (former patient room) is now being used as a storage room. The door is solid bonded wood	K 029	A self closing device was installed on the door for room 225 on 6/11/15. The director of Building and Grounds shall be responsible to ensure all storage room doors are self closing in the future.	6/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/03/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 core, but does not have a self closing device on it. Storage room doors shall be self closing. This deficient practice was verified by the Safety Officer (KH) at the time of exit.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview the exit corridor of the care center is being used for storage. In accordance with LSC(00) sections 19.2.1 & 7.10.1, exit are to be maintained free of objects that could/would obstruct egress at all times. This deficient practice could effect all patients, staff and visitors. Findings include: During the facility tour on 6-3-15 at 9:15 AM it was observed and confirmed by interview with a staff person that a hoyer lift was being stored in the exit corridor when not in use. The staff person was observed plugging the charging unit of a hoyer into an outlet in the exit corridor. When asked how long it might be left in the corridor she responded "maybe the entire shift". It was further observed that a med cart did not move in the corridor from 0830-1000 hours. These deficient practices were confirmed by the	K 038	Exit corridors will not be used as storage areas. All movable equipment will be removed from exit corridors when not in use. Any equipment needing an electrical source will be charged in locations other than the exit corridors. Nursing staff will remove medication cards from exit corridors when not actively administering medications to residents. Jeffrey Brown, SHCC Administrator, will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	6/30/15

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	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/03/2015**

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

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K 038	Continued From page 4 Facility Safety Officer (KH)at the time of exit.	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING **02 - DINING/ACTIVITY** B. WING _____	**06/03/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Building #2 "New" Nursing Home Dining Room Addition FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Communinty Memorial Hospital-Sunnyside NH (bldg. #2) was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 482.41(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. Community Memorial Hospital-Sunnyside NH,Building #2 (New Nursing Home)) is a 3 story building with a full basement, Type I (332) construction. The building was constructed in 2012/2013 and is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in corridors, spaces open to the corridors and sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 42 at the time of the survey. NOTE: The Community Memorial Hospital-Sunnyside NH and is not 2 hour fire separated. Therefore, this inspection is broken down into 2 distinctly different parts. i,.e, New Hospital, and New Nursing Home, Exist Hospital & Existing Nursing Home This is based on the different years of construction.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/01/2015

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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	245045	A. BUILDING **02 - DINING/ACTIVITY** B. WING _____	**06/03/2015**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 482.41(a) is met.	K 000		