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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GNSQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00016

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245597**
2.STATE VENDOR OR MEDICAID NO.
(L2) **863840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE CARE CENTER**
(L4) **16561 US HIGHWAY 10**
(L5) **LAKE PARK, MN** (L6) **56554**

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 11/25/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (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
	42			
(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 completed on November 25, 2013, 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 for both health and life safety code. Effective November 3, 2013, the facility is certified for 42 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 11/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 01/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1992
(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
12/02/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5597 January 16, 2014

Ms. Danielle Olson, Administrator
Sunnyside Care Center
16561 Us Highway 10
Lake Park, Minnesota 56554-9302

Dear Ms. Olson:

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 November 3, 2013, the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 16, 2014

Ms. Danielle Olson, Administrator
Sunnyside Care Center
16561 Us Highway 10
Lake Park, Minnesota 56554-9302

RE: Project Number S5597022

Dear Ms. Olson:

On October 30, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 27, 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 November 25, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 21, 2013, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 27, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 27, 2013, effective November 3, 2013 and therefore remedies outlined in our letter to you dated October 30, 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245597	A. Building B. Wing	11/25/2013

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **11/02/2013**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **10/11/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/03/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/20/2013**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **10/30/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/11/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GA/cbl	**Date:** 01/16/2014	**Signature of Surveyor:** 28034	**Date:** 11/25/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/27/2013

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245597	A. Building B. Wing 01 - MAIN BUILDING 01	11/21/2013

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

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 K0054	Correction Completed 10/14/2013	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/cbl	Date: 01/16/2014	Signature of Surveyor: 03006	Date: 11/21/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/26/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GNSQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00016

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245597**
2.STATE VENDOR OR MEDICAID NO.
(L2) **863840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE CARE CENTER**
(L4) **16561 US HIGHWAY 10**
(L5) **LAKE PARK, MN** (L6) **56554**

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 **09/27/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (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
	42			
(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 :
Denise Erickson, HFE NE II — 11/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Enforcement Specialist — 12/02/2013 (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
02/01/1992
(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
12/02/2013
(L33)

DETERMINATION APPROVAL

CCN 24-5597

At the time of the standard survey completed September 27, 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 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4523

October 30, 2013

Ms. Danielle Olson, Administrator
Sunnyside Care Center
16561 US Highway 10
Lake Park, Minnesota 56554-9302

RE: Project Number S5597022

Dear Ms. Olson:

On September 27, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537-3858

Telephone: (218)332-5158
Fax: (218)332-5196

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 November 6, 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 November 6, 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 December 27, 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 March 27, 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: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING _____ B. WING _____	09/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

(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	OK 11-12-13 PLH	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. 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	F 164	F164 1. Corrective Action: A. LPN who administered insulin for Resident #11 and #31 in the dining room was interviewed by the DON. B. The DON determined this was against our policy and procedures. C. DON documented verbal counseling in the personal file of the one nurse involved. She verbalized understanding. Medex updated to remove "with meals" and the time of administration was changed to allow prior to meals on those the MD felt should be ordered this way while others are individualized for their particular need.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danielle Olson — TITLE: Executive Director — (X6) DATE: 11/04/13

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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MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING _____ B. WING _____	09/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

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F 164	Continued From page 1 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 ensure each resident's right to personal privacy, for 2 of 2 residents (R31, R11) reviewed in the sample for privacy. Findings include: R31 had diagnoses which included Parkinson's disease, depression, and diabetes. R31's annual Minimum Data Set (MDS), dated 8/15/2013, identified R31 was rarely understood, and had moderately impaired decision making skills. The MDS identified R31 required total assistance of two facility staff for dressing, bed mobility, toileting, and personal hygiene, and utilized a wheel chair for mobility in the facility. Further, the MDS identified R31 received daily injections of Insulin. Review of R31's care plan, revised 9/18/13, directed staff to explain all procedures using simple commands and provide cueing and prompting for personal care due to an alteration in cognition related to a traumatic brain injury. During observations of the evening meal on 9/23/2013, at 5:13 p.m. 16 residents were seated at seven dining tables in the main area of the Cormorant dining room. At 5:13 p.m., R31 was seated in a high backed	F 164	F164 Continued 2. Corrective Action as it applies to Other Residents: A. The policy/procedure for administering injections as it pertains to personal privacy is correct. B. The entire nursing staff has been educated and monitored via audits and voice understanding. Date of Completion: 11/02/2013 3. Reoccurrence will be Prevented by: A. Staff education completed 10-17-2013 B. Random audits by nursing staff ongoing. 4. The Correction will be Monitored by: A. DON or designee. B. DON will report summary of audits to QA Committee.	

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F 164	Continued From page 2 wheel chair at a dining table, with another male resident at the table. licensed practical nurse (LPN)-A approached R31, stated she had his insulin, immediately lifted up his shirt sleeve to expose the upper left arm and injected the medication. This was within view of the other residents, staff and visitors in the dining room. During interview on 9/23/13, at 5:15 p.m. LPN-A confirmed she had administered the medication for R11 in the dining room. She stated she routinely administered injections to residents in the dining room. R11 had diagnoses which included developmental delay and diabetes. R11's quarterly MDS dated 7/15/13, identified R11 had moderate cognitive impairment, required limited assistance with dressing, personal hygiene and toileting. Further, the MDS identified R11 received daily injections for insulin and ambulated independently in the facility with a walker. Review of R11's care plan, revised 9/30/13, directed staff to provide R11 assistance and cues with ADLs due to delayed development. On 9/23/13, at 5:18 p.m. R11 was seated in a dining chair at a dining table with another male resident in the Cormorant dining room. LPN-A approached R11, stated she had his insulin, lifted up R11's shirt sleeve to expose the upper right arm and injected the medication. This was within view of the other residents, staff and visitors in the dining room. During interview on 9/26/13, at 10:55 a.m., R38 stated she had frequently observed injections given to residents at the dining table during mealtime. R38 stated it used to bother her but	F 164		

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F 164	Continued From page 3 now she looks away when it happens. During interview on 9/26/13, at 2:01 p.m. R25 stated that she had observed administration of injections at the dining table at almost every meal. During interview on 9/27/13, at 10:30 a.m. director of nursing (DON) confirmed that administering injectable insulin medication in the dining room with other residents present was not acceptable facility practice. The DON stated the nursing staff should not be administering injectable insulin medication in the dining room. She indicated residents should been provided privacy during treatments. Facility policies regarding injectable medication administration and policies were requested, none were provided.	F 164		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278	F278 1. Corrective Action: A. Resident #29 was reassessed to include the tooth that remains. B. Nurse involved in the error was coached on 9-30-13 to fully look into resident's mouth with assessment and not assume assessments prior were correct. Coaching form placed into her personal file. She verbalized understanding. Note there was a change in MDS coordinators in Dec of 2012.	

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F 278	Continued From page 4 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the comprehensive assessment accurately reflected the dental status for 1 of 3 residents(R29) reviewed with dental needs. Findings include: R29's diagnoses included dementia and depression. The significant change Minimum Data Set (MDS) dated 8/26/13, identified R29 was rarely/never understood and required assistance with all activities of daily living. The MDS identified R29 had no natural teeth, and was not identified to have loose fitting upper partial denture. The Care Area Assessment, dated 9/2/13, identified R29 did not have any of her own teeth and wore upper and lower dentures and indicated no issues with eating noted. Review of R29's clinical record revealed a form titled, Resident Admission/ Readmission Information, dated 8/20/13, and identified R29 to	F 278	F278 Continued 2. Corrective Action as it applies to Other Residents: A. The policy and procedure for dental assessment is correct. B. The revision to resident #29 care plan was completed on 10-04-2013. C. All other current residents were reassessed and care plan was updated if needed. 3. Date of Completion: 10/11/2013 4. Reoccurrence will be Prevented by: A. DON or designee will audit a new record per week to assure assessments are complete including dental. 5. The Correction will be Monitored by: A. DON or designee. B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 278	Continued From page 5 have "difficulty chewing, upper and lower dentures," and required a "mechanical soft diet." During observation on 9/25/13, at 8:54 a.m. nursing assistant (NA)-C assisted R29 to brush her teeth, upper partial denture, and a full lower denture. NA-C indicated R29 had a partial plate in place which was utilized with two of R29's natural teeth in the back of her mouth. During interview on 9/25/13, at 9:00 a.m. NA-C confirmed that R29, "had a couple of teeth on top." During interview on 9/27/13, at 9:24 a.m., R29 when asked about teeth, moved her tongue around in mouth and stated, "I do have some teeth back there." R29 then confirmed she felt one tooth on each side on the upper mouth. During interview on 9/27/13, at 10:00 a.m., the director of nursing(DON) confirmed R29's comprehensive assessment and stated she would expect assessments to be accurate of the resident's needs. Requested policies for dental assessment were not provided.	F 278		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F314 1. Corrective Action: A. Resident #51 continued to be repositioned every hour per plan of care as evidenced by her turning sheet. She was reassessed via skin tissue tolerance and found to be able to tolerate every 2 hour	

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F 314	Continued From page 6 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning for 1 of 1 recently admitted residents (R51) with a current stage 3 pressure ulcer. Findings include: R51's diagnoses included, stage 3 pressure ulcer(full thickness tissue loss) on the right buttock, dementia, renal failure, and uterine cancer. The admission Minimum Data Set (MDS), dated 9/18/13, identified R51 had severe cognitive impairment and was totally dependent on staff for all activities of daily living. Further, the MDS identified R51 had been admitted with a stage 3 pressure ulcer. Review of R51's clinical record revealed a form titled, Skin Assessment dated 9/13/13, identified R51 had a current pressure ulcer, was bed fast or chair bound and had a Braden score of 18 or less (tool for assessing risk of pressure ulcer development, indicating at risk for development of pressure ulcer.) The form identified "Resident placed on repositioning Q (every) 1 hour. Resident has pressure ulcer on buttock, present upon admission. Very minimal bed mobility extensive assist with repositioning." The initial care plan, dated 9/5/13, identified R51 had an open area on the buttocks with the identified goal to heal the open area. The care	F 314	F314 Continued repositioning and the plan of care was updated on 10-20-13. This is monitored by the LPN or RN wing nurse. The specific NA-R involved was coached on correct plan of care for Resident #51. Coaching form was placed into her personal file. She verbalized understanding. 2. Corrective Action as it applies to Other Residents: A. The policy and procedure for skin care/pressure ulcer care is correct as written. B. All nursing staff is aware of the need to follow the individual plan of care for each resident. A nurse meeting was held on October 17th and Nurse's aide meeting held on Oct 29th, 2013. Those nurses unable to attend received written communication. 3. Date of Completion: 11/03/2013. 4. Reoccurrence will be Prevented by: A. DON or designee will randomly observe staff for accurate/timely fulfillment of individualized plan of care.	

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F 314	Continued From page 7 plan included various interventions which included pressure relief bed, blue booties and reposition every hour. During continuous observations on 9/25/13, from 7:55 a.m. until 9:55 a.m. R51 was observed laying in bed on her left side, eyes closed resting with a pillow placed behind her back. R51 had blue heal protector booties on both feet and feet elevated on a pillow. At 9:55 a.m. nursing assistant (NA)C entered R51's room to assist NA-B to reposition R51 on to her right side. R51 had not been repositioned for a total of 2 hours. During interview on 9/25/13, at 10:00 a.m.. NA-B confirmed that R51 had remained in the same position without repositioning since 7:55 a.m. NA-B stated R51 required a hourly reposition schedule. During continuous observation on 9/26/13 from 8:45 a.m., to 9:35 a.m., R51 remained seated in a wheelchair, with her eyes closed, resting in a lounge area of the facility. At 9:35 a.m., licensed practical nurse (LPN)-B wheeled R51 into her room and assisted R51 to transfer into bed. R51 had not been repositioned for a total of one hour and 35 minutes. On 9/26/13, at 9:41 a.m., NA-D stated she had assisted R51 to get into the wheelchair between 8-8:15 a.m. and confirmed R51 was to be repositioned every one hour. During observation of the pressure ulcer dressing change on 9/26/13, at 1:36 p.m. a open are was observed over the coccyx area and the beefy red wound bed appeared moist and clean. The tissue immediately adjacent to the pressure ulcer was	F 314	F314 Continued 5. The Correction will be Monitored by: A. DON or designee. B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 314	Continued From page 8 light pink, with a dark pink rash observed to cover both buttocks and upper thighs. LPN-B cleaned the pressure ulcer, applied hydrogel (a jelly like material that maintains a moist environment and absorbs excess drainage), covered the pressure ulcer with Aleven (dressing that maintains moisture level and provides protective bacterial barrier) and applied Sensi cream (a protective barrier cream) to the rash area. During interview on 9/27/13, at 10:00 a.m. the director of nursing (DON) confirmed R51 had a current stage 3 pressure ulcer. She confirmed the current care plan for R51 and verified she would expect the care plan to be followed. The facility policy titled Care Plan-Temporary, dated 5/2011, identified, "Care is planned to help attain or maintain the resident's/patient's highest practicable physical, mental and psychosocial well being." The facility policy titled Skin Care/Pressure Ulcer Care, dated 5/2011, identified, "Routine skin care is provided to promote healing and prevent complications. Skin problems are identified and treatments instituted promptly."	F 314		
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.	F 323	F323 1. Corrective Action: A. Individual NA-R involved in the error was coached immediately by DON. Plan of care for Resident #51 was updated on 9-25-13 to include leaving the lift sling under her to avoid the difficulty of placement with each transfer. One size smaller	

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F 323	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize resident care equipment to ensure safety with transfers for 1 of 1 resident (R51) who required a mechanical lift for transfers. Findings include: During observation on 9/25/13, at 7:48 a.m. nursing assistant (NA)B and NA-C placed the EZ Way Smart Lift cloth sling beneath R51, who was seated in a wheel chair. The straps of the sling where then attached to a EZ Way Smart Lift (EZ, mechanical lift device) and R51 was elevated out of the wheelchair, suspended into the air between the wheelchair and bed by the EZ lift. During the entire transfer, the fabric of the sling was rolled upward on R51's back at the height of her waist. R51's lower back below the waist, entire buttocks and upper thighs were not covered by the fabric sling. On 9/25/13, at 7:55 a.m., NA-B confirmed the positioning of the lift sling was not correct. NA-B stated positioning of the lift sling, " is hard to get it under [R51] when she is sitting." She stated she did not leave the sling on R51 when in the wheelchair and stated R51 could potentially "get sore." Review of The EZ Way Smart Lift operators manual, revised 12/21/10, revealed, "Transferring patient from chair, wheel chair, or toilet. step 1 #2 Make sure the base of the sling touches the chair seat and is 2 inches below the tailbone."	F 323	F323 Continued lift sheet was purchased and was being used for this resident. Resident has since been reassessed and is a 2 person transfer as of 10-26-13. 2. Corrective Action as it applies to Other Residents: A. All staff was in attendance or viewed an inservice by Kim Betts of EZ Lift. B. All nursing staff has been observed while using the lifts. 3. Date of Completion: 10/20/2013 4. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least two times a week, observe transfers with lifts to be assured proper procedure is followed. 5. The Correction will be Monitored by: A. DON or designee. B. The DON will summarize the care observation results and present the information to the QA Committee on a quarterly basis for further direction.	

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F 323	Continued From page 10 During interview on 9/25/13, at 1:33 p.m. the director of nursing (DON) confirmed R51 utilized a mechanical lift for transfers. She confirmed safety for residents during transfers was important.	F 323		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to perform an accurate dental assessment for potential dental needs for 1 of 3 residents (R29) in the sample reviewed for dental status. Findings include: R29's diagnoses included dementia and depression. The significant change Minimum Data Set (MDS) dated 8/26/13, identified R29 was rarely/never understood and required	F 411	F411 Corrective Action: A. Resident #29 was reassessed to include the tooth that remains. B. Nurse involved in the error was coached on 9-30-13 to fully look into resident's mouth with assessment and not assume assessments prior were correct. Coaching form placed into her personal file. Note there was a change in MDS coordinators in Dec of 2012. C. All RNs in charge of care planning attended a meeting regarding dental regulations and assessment and are aware of the need to fully fill out quarterly forms and offer an appointment with the dentist at least yearly and chart the results. Resident # 29 and family decline dental visit. 2. Corrective Action as it applies to Other Residents: A. The policy and procedure for dental assessment is correct. B. The revision to resident #29 care plan was completed on 10-04-2013. C. All other current residents were reassessed and care plan was updated if needed.	

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F 411	Continued From page 11 assistance with all activities of daily living. The MDS identified R29 had no natural teeth, and was not identified to have loose fitting upper partial denture. The Care Area Assessment, dated 9/2/13, identified R29 did not have any of her own teeth and wore upper and lower dentures and indicated no issues with eating noted. R29's care plan, revised 9/18/13, identified the problem of alteration in dental status related to upper and lower dentures and listed various interventions which included ongoing observation of condition of oral cavity. Review of R29's clinical record revealed a form titled, Resident Admission/ Readmission Information, dated 8/20/13, and identified R29 to have "difficulty chewing, upper and lower dentures," and required a "mechanical soft diet." During observation on 9/25/13, at 8:54 a.m. nursing assistant (NA)-C assisted R29 to brush her teeth, upper partial denture, and a full lower denture. NA-C indicated R29 had a partial plate in place which was utilized with two of R29's natural teeth. During interview on 9/25/13, at 9:00 a.m. NA-C confirmed that R29, "had a couple of teeth on top." During interview on 9/27/13, at 9:24 a.m. R29 when asked about teeth, moved her tongue around in mouth and stated, "I do have some teeth back there." R29 then confirmed she felt one tooth on each side on the upper mouth. During interview on 9/27/13, at 10:00 a.m., the director of nursing(DON) confirmed R29's care	F 411	F411 Continued D. RNs have offered dental visits to all residents and will continue to do so at least yearly. 3. Date of Completion: 10/30/2013 4. Reoccurrence will be prevented by: A. DON or designee will audit a new record per week to assure assessments are complete including dental. She will also audit for dental visits being offered to all on at least a yearly basis. 5. The Correction will be monitored by: A. DON or designee. B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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	245597	A. BUILDING _____ B. WING _____	09/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 411	Continued From page 12 plan and stated she would expect assessments to be accurate of the resident's status and needs. Requested policies for dental assessment were not provided.	F 411		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 Corrective Action: A. All staff involved in the improper practice was coached immediately on following proper procedure in regard to infection control-use of gloves and linen handling. B. Date of Completion: 10/11/2013 Corrective action as it applies to other residents: A. The policy and procedure were reviewed and found to be correct. B. All nursing staff has been made aware and monitored via audit for compliance. Reoccurrence will be prevented by: A. DON or designee will audit all nursing staff by November 2, 2013 and coach anyone not following procedure.	

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F 441	Continued From page 13 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation interview, and document review, the facility failed to ensure infection control practices was followed with soiled linen handling for 1 of 1 resident(R51) with an infectious wound, and failed to ensure infection control practices were followed related to multi use care equipment for 1 of 1 resident(R29) during observations of personal cares. Findings include: R51 had been diagnosed with Methicillin Resistant Staphylococcus Aureas (MRSA) (a antibiotic resistant infection) in an open sore on her buttocks. During observation on 9/25/13, at 7:31 a.m. a soiled pink cloth pad, hospital gown and wet wash cloth and towels lay on top of the small bedside dresser next to R51's water mug and box of Kleenex. Nursing assistant (NA)-B with gloved hands removed the soiled linens from the top of R51's bed side dresser and placed them into a red biohazard bag and walked out of the R51's room to dispose of the soiled linens. NA-B placed the soiled linens in a biohazard bin, removed her gloves and proceeded to wash her hands. During interview on 9/25/13, at 7:35 a.m. NA-B confirmed that the pink soaker pad, hospital gown	F 441	F441 Continued B. DON or designee will randomly observe staff on infection control procedure for proper practice. The Correction will be Monitored by: A. DON or designee. B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 441	Continued From page 14 and towels piled on top of the bed side dresser were from morning cares and were soiled. NA-B stated R51's clothes, linen,and personal laundry were sent to laundry in a red bag, because of, "an infection [MRSA] in an open sore on [R51's] bottom." NA-B confirmed that she was done in the room and left the room with out washing or disinfecting the dresser or table tops. The facility form titled Transmission -Based Precautions:Contact Precautions identified, "Modes of MRSA Transmission * Direct transmission after contact with the MRSA-contaminated skin or body fluids of a patient who is colonized or infected with MRSA. *Indirect transmission after contact with a MRSA-contaminated object or environment." During interview on 9/27/13, at 10:00 a.m. the director of nursing (DON) confirmed that R51 did have MRSA in a wound and that, "all linens are considered hazardous." Disinfection of a multi use device was not completed between residents after contamination. During observation of morning cares on 9/25/13, at 8:54 a.m., NA-C donned gloves brushed R29's teeth, then brushed and handed R29 her upper partial and lower denture. With the same wet gloves used for oral cares, NA-C retrieved the walkie talkie from her uniform pants side pocket to respond to another NA's page. NA-C then returned the walkie talkie to the side pocket of her uniform pants. After completing cares NA-C removed her gloves, washed her hands and left R29's room to continue on with her duties. NA-C had not disinfected the walkie talkie after handling	F 441		

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F 441	Continued From page 15 the device with dirty gloves. During interview on 9/25/13, at 9:48 a.m. NA-C confirmed that the walkie talkie had been handled with soiled gloves and she had not disinfected it between residents. She confirmed she utilized the walkie talkie routinely while working with residents. NA-C stated, "I didn't even think about it." The facility provided form titled, Transmission -Based Precautions :Contact Precautions read, "Expected Outcomes Related to Standard Precautions, The use of Standard Precautions is intended to protect residents by ensuring that health care personnel do not transmit infectious agents to residents via their hands or equipment used during resident care." Further, the policy directed staff to handle contaminated equipment in a manner to prevent transmission of infectious agents. During interview on 9/27/13, at 10:00 a.m., the DON confirmed that walkie talkies should be disinfected, "if inadvertently touched before going on to another resident." She confirmed the current facility policy directed staff to utilize standard precautions for all residents and related care equipment at all times.	F 441		

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

F 5597022

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building (1975 Building) THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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. At the time of this survey Sunnyside Care Center 01 Main Building 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	RECEIVED NOV – 4 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok JB 11-6-13	

DC: 11.06.2013

Exit: 09.27.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	11/04/13

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	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us and
Barbara.Lundberg@state.mn.us

Fax Number 651-215-0525

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

The Sunnyside Care Center is a 1-story building without a basement. The building was constructed in 1975 and is of Type II (000) construction. An entrance and dayroom additions were constructed to the north and south of the original building in 2004 and are Type V (111) construction. The facility is divided into three smoke zones by 1-hour fire barriers.

The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with corridor smoke detection and sleeping room smoke detection on it that are installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The fire alarm is monitored for automatic fire department notification. The facility also has automatic fire

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K 000	Continued From page 2 detection in accordance with the Minnesota State Fire Code (2007 edition). The facility was surveyed as two buildings. 01 The Main Building (1975 construction), existing health care and 02 Entrance Additions (2004), new health care The facility has a capacity of 45 beds and at the time of the survey the census was 40 residents. During the entrance conference the Administrator indicated that the facility meets the 2012 Life Safety Code for having fixed furniture in the corridor system (K72). A waiver for this deficiency has been approved in the past. Observations during the facility tour on September 26, 2013, between 10:30 am and 12:00 pm, revealed that two chairs and a table are in front of the nurse's station restricting the corridor width to less than 8 feet and are fixed to the floor. The requirement at 42 CFR, Subpart 483.70(a) in 01 Main Building is NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observations, it was determined that two of approximately 50 smoke detectors are not installed in accordance with NFPA 72 " The National Fire Alarm Code" 1999 edition section	K 054	K054 Corrective Action 1. How the deficiency will be corrected: A. Environmental Services Coordinator reviewed "The National Fire Alarm Code" on 10/07/13.	

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K 054	Continued From page 3 2-3.5.1. Improper location of smoke detectors may allow a delay in alarming staff, causing a delay in the response to the fire emergency, which would negatively impact all 49 of the residents, all staff and any visitors of the facility. Findings include: Observations during the facility tour on September 26, 2012 between 10:30 am to 12:00 pm, by surveyor 03006, revealed that the 2 corridor smoke detectors, near the dining room are in the air stream of the HVAC system. The south smoke detector is within 3 feet of a supply diffuser and the north smoke detector is within 3 feet of the return air grill. The CEO verified this finding during the facility tour and during the exit conference.	K 054	K054 Continued B. The two (2) corridor smoke detectors were moved away from the HVAC system to be in compliance with NFPA 72 "The National Fire Alarm Code" 1999 edition section 2-3.5.1. on 10/14/2013. 2. Completed on 10/14/13. 3. Environmental Services Coordinator and Administrator will monitor.	

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

F5597022

FORM APPROVED
OMB NO. 0938-0391

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	245597	A. BUILDING 02 - ADMINISTRATION ADDITION B. WING _____	09/26/2013

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Entrance Addition A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Sunnyside Care Center 02 Entrance Addition was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The Sunnyside Care Center is a 1-story building without a basement. The building was constructed in 1975 and is of Type II (000) construction. An entrance and dayroom additions were constructed to the north and south of the original building in 2004 and are Type V (111) construction. The facility is divided into three smoke zones by 1-hour fire barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with corridor smoke detection and sleeping room smoke detection on it that are installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The fire alarm is monitored for automatic fire department notification. The facility also has automatic fire detection in accordance with the Minnesota State Fire Code (2007 edition).	K 000	11-6-13 RECEIVED NOV - 4 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	11/4/13

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K 000	Continued From page 1 The facility was surveyed as two buildings. 01 The Main Building (1975 construction), existing health care and 02 Entrance Additions (2004), new health care The facility has a capacity of 45 beds and at the time of the survey the census was 40 residents. The requirement at 42 CFR, Subpart 483.70(a) in 02 Entrance Addition MET.	K 000		