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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K1EM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00338

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245357**

2. STATE VENDOR OR MEDICAID NO. (L2) **599245100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA SUNRISE MANOR**
(L4) **240 WILLOW STREET**
(L5) **TYLER, MN** (L6) **56178**

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) **03/01/2016**

6. DATE OF SURVEY **5/30/2017** (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) **02/28**

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

12.Total Facility Beds **38** (L18)

13.Total Certified Beds **38** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	38			
(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 :
Pamela Manzke, HFE NE II 8/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 8/11/2017 (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 **05/01/1986** (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. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245357 August 11, 2017

Mr. Allen Anderson, Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

Dear Mr. Anderson:

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

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

Effective May 1, 2017 the above facility is certified for:

38 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 38 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us
cc: Licensing and Certification File

Electronically delivered
August 11, 2017

Mr. Allen Anderson, Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

RE: Project Number S5357027

Dear Mr. Anderson:

On May 26, 2017, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 23, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of May 26, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 23, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on March 23, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our May 26, 2017 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 31, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 1, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 23, 2017, as of May 1, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of May 26, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 23,

2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 23, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 23, 2017, is to be rescinded.

In our letter of May 26, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 23, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 1, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 26, 2017

Ms Mary Maertens, Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, Minnesota 56178

RE: Project Number S5357027

Dear Ms. Maertens:

On April 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 23, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 1, 2017. However, compliance with the health deficiencies issued pursuant to the March 23, 2017 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 23, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 23, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 23, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Avera Sunrise Manor is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 23, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

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 June 23, 2017 (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

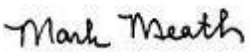
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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.

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

Sincerely,



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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K1EM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00338

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245357**
2.STATE VENDOR OR MEDICAID NO.
(L2) **599245100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA SUNRISE MANOR**
(L4) **240 WILLOW STREET**
(L5) **TYLER, MN** (L6) **56178**

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) **03/01/2016**

6. DATE OF SURVEY **03/23/2017** (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)
02/28

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

12.Total Facility Beds **38** (L18)
13.Total Certified Beds **38** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	38			
(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 :
Lois Boerboom, HFE NE II 04/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/19/2017 (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
05/01/1986
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 7, 2017

Ms. Mary Maertens, Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

RE: Project Number S5357027

Dear Ms. Maertens:

On March 23, 2017, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

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

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

Remedies - 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 2, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 June 23, 2017 (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 September 23, 2017 (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 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

(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 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an individualized activity program for 1 of 1 resident (R26) reviewed for activities. Findings include:	F 248	Activity Coordinator to complete current lifestyle assessment on identified resident. Activity Coordinator to create activity care plan based on resident preferences on identified resident. Activity Coordinator to complete lifestyle assessment on all current residents with	5/1/17

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

Electronically Signed | 04/14/2017

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

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F 248	Continued From page 1 The physicians order sheet documented R26 with diagnoses including: Parkinson's disease, Alzheimer's disease, dementia, anxiety disorder and Major depressive disorder. The most recent quarterly Minimum Data Set (MDS) assessment was dated 12/16/16. The MDS identified R26 as having a Brief Interview of Mental Status (BIMS) score of 7/15 indicating severe cognitive impairment. The PHQ-9 (an assessment tool for determining depression) scored 10/27 which indicated moderate depression. The MDS activities of daily living (ADLs) indicated R26 required limited assistance with transfers, bed mobility, walking in room, corridor and locomotion on/off the unit; extensive staff assistance required with dressing, toileting, and personal hygiene. Behaviors during the assessment period were coded as not occurring (0) and the activities preferences assessment was blank (0). R26's care plan dated 6/29/16, listed a problem related to cognitive status evidenced by (e/b) short term memory problem, long term memory problem, impaired decision making and disorganized thinking. The only intervention identified was "cueing". The problem identified as activity involvement dated 12/22/16, included the following interventions: (1) listens to music in room, (2) rummages through things, (3) wanders the halls, (4) one to one (1:1) visits (daughter visits her at mealtime daily), (5) assess likes/dislikes: does not care to be involved in most group activities; sometimes participates in exercises, music and bowling depending on the day and mood and if she does attend, will leave early, and (6) spiritual assessment. The nursing assistant (NA) Assignment Sheet- Set 1, a	F 248	MDS schedule Activity Coordinator to complete activity care plan based on resident preferences with MDS schedule for all residents Activity Coordinator to complete current lifestyle assessment upon admission to determine resident preferences for activities. Activity Coordinator to create individualized activity care plan based on resident preferences for all new admissions. \Resident preferences for independent activities will be added to resident care sheets. Activity Coordinator to develop activity calendar based on residents' preferences. Development of policy for activity programming, assessment, and care planning.- completion of preference assessment upon admission and annually. Assignment of completion of activity programming when activity coordinator is not in-house Education at April staff meeting on how to document resident attendance at activity programs. Revision of aide orientation checklist to include how to document resident attendance at activities. DON will monitor compliance with individualized activity care plan by monitoring 10% of residents on a monthly basis. Tracking tool will be created and used for monitoring. Results will be entered into the facility quality scorecard. Facility quality scorecard to be reviewed at	

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F 248	Continued From page 2 revision date of 2/7/17, included: (1) likes music in room; (2) doesn't like loud noises. No additional activity nor restorative information was included on the NA assignment document. The following observations were noted during the survey on 3/20, 3/21, 3/22 and 3/23/17: (1) On 3/20/17, during continuous observations from 3:00 p.m. until 4:30 p.m. R26 was noted to be wandering up and down both hallways and in/out of her room and again down the hallway. Staff were noted to communicate with R26 as they walked nearby and R26 responded with soft, garbled speech as she continued to ambulate. A large assortment of CD music was evident in R26's room and yet no music was provided when R26 was either lying on her bed or seated in her recliner. (2) On 3/21/17, at 10:50 a.m. R26 was observed walking in the halls using her walker, and attempting to exit the doors located at the end of each hallway. When unable to open the door, R26 turned and continued to ambulate down the length of the hall. R26 did respond to staff greetings but continued to walk into the day room area, up/down the hallway, to the nurses' station, into the adjacent dayroom and back down the hall. R26 was stopped by registered nurse (RN)-A, who requested she return to her room for medication administration. R26 stopped, listened to RN-A's request and then continued to walk down the hallway, peering into resident rooms as she walked by, not attempting to enter. After reaching the end of the hall, R26 proceeded to walk back down the hall. At 11:12 a.m. R26 was again stopped by RN-A, who redirected her into her room for medication administration. At 11:27	F 248	department meetings, monthly quality meetings, and Admin Council monthly. Activity Coordinator to track compliance with completion of documentation of attendance. Results reported on quality scorecard.	

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F 248	Continued From page 3	F 248		

a.m. R26 continued to wander the halls. No activity was offered by staff.

(3) On 3/21/17, at 11:41 a.m. R26 wandered into her room, laid down on the bed and appeared to be asleep. No music was noted during this time. In addition, the activity calendar indicated exercises were to be held at 11:30 a.m. in the dining room. No exercise activity was noted to be initiated as of 11:43 a.m. When questioned who was responsible to lead the activity., NA-A responded "whoever had time was suppose to perform the activity" but it frequently didn't occur as everyone was busy. NA-A further explained that afternoon activities were held more consistently since it wasn't as busy at that time of the day.

(4) On 3/21/17, at 2:38 p.m. R26 was observed resting in bed, since consuming her noon meal. No music was playing at this time. It was noted that during this time, the activity horse races, was held in the dining room. R26 remained in her room, and staff were not aware whether R26 had been invited to attend.

(5) On 3/22/17, at 7:15 a.m. R26 was resting quietly in bed. No music had been provided. At 8:38 a.m. R26 remained lying in bed. NA-A indicated R26 frequently slept later in the mornings. At 8:58 a.m. NA-A entered R26's room, assisted her from bed, helped with her grooming and assisted her to the dining room for breakfast.

When interviewed on 3/21/17, at 2:39 p.m. NA-C explained that R26 is assisted with cares, requires redirection and likes to wander in the hallways. NA-C further stated R26 rarely attends

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F 248	Continued From page 4	F 248		

activities and when she does, she sits off to the side of the group. NA-C indicated R26 prefers to sit in her room and listen to music, but not certain whether R26 had been listening to her music lately.

When interviewed on 3/22/17, at 9:33 a.m. NA-A stated that R26's daily routine includes wandering into the day room and/or hallway, watching television and/or naps in her recliner. During a subsequent interview on 3/22/17, at 2:34 p.m. NA-A confirmed R26 remained asleep in her bed during the exercise activity held at 11:30 a.m. and again during the backpack activity at 2:30 p.m. NA-A explained the backpack activity involved placing food items in backpacks for school age children. NA-A indicated she was uncertain whether R26 had been offered/encouraged to attend either activity.

Documentation in the medical record was lacking to indicate R26 had been involved in a daily exercise program and that 1:1 visits. Review of the activity calendar indicated exercises were offered daily, social time was scheduled for Tuesday (3/21) and Wednesday (3/22/17) and devotions on Thursday 3/23/17. R26 was observed wandering in the halls and/or sleeping on her bed during each of these activity times. No music was noted to be provided while R26 was in her room.

The interim director of nursing (DON) was interviewed on 3/23/17, at 10:00 a.m. and confirmed an updated activity assessment was lacking for R26 and her expectation was that it be completed at the time of admission with review and updates with each assessment. In addition, it was confirmed the NA-assignment sheet was

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F 248	Continued From page 5 not up to date regarding R26's activity needs. No policy was provided with regard to activity assessments and/or expectations.	F 248		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 309		5/1/17

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F 309	Continued From page 6 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide proper positioning during meal time for 1 of 1 resident (R20) reviewed who was fed while slumped forward in the wheelchair. Findings include: R20's quarterly Minimum Data Set (MDS) assessment dated 3/2/17, identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS identified R20 with a balance problem with transfers and standing and indicated R20 required extensive assistance of staff with all activities of daily living (ADL's). R20's Physician Orders dated 2/1/17, identified diagnoses including: osteoarthritis, anxiety, pain, hypertension, coronary artery heart disease and advanced Alzheimer's disease. During observation of the evening meal on 3/20/17, at 6:05 p.m. R20 was wheeled in a high back wheelchair into the dining room and placed at the dining room table. R20 was seated in her wheelchair, leaning forward with her face hanging down toward her lap. At 6:12 p.m. nursing assistant (NA)-E sat next to R20 and started feeding her by bringing food up and under her face. NA-E assisted R20 during the entire evening meal while R20's face was hanging down toward her lap and she was in a slumped position. There was no attempt by staff to	F 309	OT/ST consults for identified resident to assist with positioning needs. Purchase wheelchair for proper positioning. OT to provide staff education on best strategies for correct positioning for meal times. Update resident care plan when new techniques as recommended by OT/ST DON to observe meal time to determine positioning concerns for other residents. Staff education to be provided at April staff meetings on feeding/positioning techniques. Aide orientation checklist revised to include positioning techniques. DON will monitor compliance by monitoring 10% of residents on a monthly basis for positioning needs. Tracking tool will be created and used for monitoring. Results will be entered onto the facility quality scorecard. Facility scorecard to be reviewed at department meetings, monthly quality meeting, and by Admin Council on a monthly basis.	

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F 309	Continued From page 7 reposition and/or sit R20 in an upright position in the wheelchair to enhance the meal service. During observation of the breakfast meal on 3/21/17, at 8:37 a.m. R20 was wheeled into dining room, slumped forward with her face down towards her lap. R29 was again observed to remain seated in a slumped position throughout the meal. When interviewed in the dining room on 3/21/17, at 8:42 a.m. the registered occupational therapist (OTR)-A stated the facility was attempting to get a different wheelchair for R20 to support her positioning. OTR-A stated that although she had evaluated R20, insurance would not pay for a new wheelchair. OTR-A confirmed that staff should attempt to sit R20 in an upright position while feeding and/or attempt to recline the wheelchair slightly to assist with positioning and promote proper positioning when fed. During interview on 3/22/17, at 10:31 a.m. the director of nursing (DON) stated it would be important to attempt to position R20 in an appropriate "eating position" .	F 309		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance	F 318		5/1/17

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F 318	Continued From page 8 to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) exercises were performed as recommended by occupational therapy (OT) for 1 of 2 residents (R5) reviewed for ROM with limited ROM. Findings include: R5's diagnoses summary sheet, undated, identified a diagnoses including: multiple sclerosis (MS), ischemic heart disease and diabetes. R5's annual Minimum Data Set (MDS) assessment dated 1/15/17, indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also identified R5 required extensive to total assistance with activities of daily living (ADL's) by 2 staff and had impairments in ROM to one lower and upper extremities. The Care Area Assessment (CAA) related to ADL's and rehabilitation potential dated 7/21/16, indicated R5 was totally dependent upon two staff for transfers. The CAA identified R5 had little to no voluntary movement in the right upper and lower extremities, required extensive staff assistance for all ADLs and was alert/oriented. R5's care plan updated 1/26/17, identified R5 had restorative nursing. Staff were to complete ROM exercises to the shoulder, elbow, hand and wrist (right side); 10 times/each daily. The care plan identified R5 required strengthening exercises with one pound weight; 3 days/week-Monday,	F 318	Therapy communication for ROM to be posted in resident closet as a communication tool for staff on correct exercises. ROM will be completed by nursing staff as per education tool at frequency recommended by PT/OT Review/revise identified resident's care plan to include ROM program. Future referrals for functional maintenance program will be routed to DON and staff by therapy placing caregiver education and written instructions in basket at nurses station with copy to DON. DON to review all resident's receiving ROM to assure plan is being followed. Review/revision of care plans for residents receiving ROM exercises to assure inclusion of program. List of current residents receiving functional maintenance programming to DON from therapy. Resident care sheets to be updated to reflect need for ROM Development of a functional maintenance program policy Staff education to be provided at April staff meeting on care planning and completion of ROM exercises. Aide orientation checklist to be revised to include functional maintenance program DON will monitor compliance with ROM program by monitoring 10% of residents	

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F 318	Continued From page 9 Wednesday and Fridays. The ROM instruction sheet was located in the chart and posted in R5's room. When interviewed on 3/21/17, at 10:23 a.m. R5 stated she was not receiving ROM exercises to the right side. When questioned whether staff provided daily exercises to the shoulder, elbow, wrist and/or hand, R5 reiterated the exercises had not been offered daily and revealed that ROM exercises had not been done for a very long time. During a interview with nursing assistants (NA)-A and NA-D on 3/21/17, at 10:17 a.m. they revealed that ROM exercises were to be completed daily by the NA's; and completed after 11 a.m. NA-A and NA-D further revealed that if the day shift staff were unable to complete ROM, this was reported to the evening shift staff and the expectation was that ROM would be completed during that shift. NA-A stated, "I'm not going to lie, sometimes, we are down [less help available], and ROM does not get done; we do our very best." During an interview on 3/22/17, at 1:31 p.m. registered occupational therapist (OTR)-A revealed she had visited with R5 prior but she is currently being seen by OT for wheelchair positioning. When evaluated on 3/23/17, 8:18 a.m. OTR-A confirmed that R5 exhibited less strength of the right side compared with the July 2016 OT evaluation. OTR-A stated, "It would be difficult to evaluate if the decline would be from lack of the exercise program, or the diagnosis of multiple sclerosis."	F 318	on a monthly basis. Tracking tool will be created and used for monitoring. Results will be entered on the facility quality scorecard. Facility scorecard to be reviewed at department meetings, monthly quality meeting, and by Admin Council on a monthly basis.	

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F 318	Continued From page 10 During interview on 2/1/16, at 11:23 a.m. the director of nursing (DON) revealed she had been unaware that R5's restorative program had not been consistently implemented by staff. Review of form titled, Restorative Nursing Program Orders dated 7/5/16, documented a description of the restorative nursing program: complete ROM exercises for shoulder, elbow, hand, wrist (right side) 10 times per exercise, daily. Complete strengthening exercises with one pound free weight three days per week on alternate days. Restorative program documentation was requested for R5 from the electronic record on 3/23/17. When reviewed, the following days lacked documentation that ROM exercise program had not been performed in 2017: 1/4, 1/5, 1/10, 1/13, 1/15, 1/19, 1/21, 1/25, 1/27, 1/29, 2/2, 2/6, 2/10, 2/11, 2/12, 2/24, 2/26, 3/1, and 3/12 (19 days). A ROM and/or restorative care policy was requested and none was submitted for review.	F 318		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and	F 328		5/1/17

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AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

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F 328	Continued From page 11 (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

(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 328	Continued From page 12 resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper technique was utilized in the administration of insulin with an insulin pen for 1 of 3 residents (R16) reviewed who received insulin via an insulin pen. Findings include: R16 had been observed on 3/22/17, at 7:54 a.m. when registered nurse (RN)-B correctly calculated the physician ordered dose of 39 units of Novolog insulin. However, RN-B had not primed the pen as directed by the manufacture of the pen as noted when RN-B dialed 39 units of insulin with the pen, cleansed the skin with an alcohol swab, uncapped the needle and prepared for injection. Prior to the administration to the resident this surveyor stopped RN-B to confirm whether the insulin pen had been primed in a private location. RN-B confirmed she had not primed the insulin pen and would have administered the insulin dose to R16. RN-B primed the pen correctly, re-dialed 39 units of insulin and administered the insulin. However, during the administration it was noted that RN-B did not leave the needle in the tissue according to the manufacturers directions for 10 seconds after injecting the insulin dose as RN-B was observed to immediately withdraw the needle after injecting the insulin solution from the pen.	F 328	Development of a competency on use of insulin pen, to be used for new employees that provide injections. Development of a medication administration policy to include use of insulin pens. Education on use of insulin pens posted in med room for current licensed staff. Education to nursing staff at nurse staff meeting on 3/23/17. Orientation checklist for RNs/LPNs reviewed to include competency on use of insulin pens. DON to monitor compliance on use of insulin pen by observing 2 staff members per month. Tracking tool will be created and used for monitoring. Results will be entered on the facility quality scorecard. Facility scorecard to be reviewed department meetings, monthly quality meeting, and by Admin Council on a monthly basis.	

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	245357	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

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F 328	Continued From page 13 On 3/22/17 at 7:55 a.m., RN-B confirmed she had not waited the 10 seconds prior to withdrawal of the insulin pen. Following review of the manufacture's recommendations for insulin pen administration, RN-B stated, "I did not know that I was even supposed to do that, thank you for letting me know." When interviewed on 3/22/17, at 8:15 a.m.,. the noted observation was discussed with the director of nursing (DON) and the lack of knowledge expressed by RN-B related to the proper use of an insulin pen. Upon requesting a policy for insulin pen usage, the DON confirmed she was uncertain whether the facility had a written procedure and indicated she was unaware of the correct procedure. Review of the package insert titled: Lantus Solostar instruction leaflet, revised July 2015, documented the following: (Step 3.) Perform safety test. Always perform the safety test before injection by: Ensuring that pen and needle work properly. Removing air bubbles. (Step 4.) Select the dose. Select a dose of 2 units by turning the dosage selector, press the injection button all the way in. Select the dose. (Step 5.) Inject the dose. B. Insert the needle into the skin. C. Deliver the dose by pressing the injection button in all the way. The number in the dose window will return to 0 as you inject. D. Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING **01 - TYLER HEALTHCARE CENTER** B. WING _____	**03/22/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA SUNRISE MANOR	**240 WILLOW STREET TYLER, MN 56178**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Tyler Sunrise Manor Healthcare Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 485.623(d), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Tyler Health Care Center - Sunrise Nursing Home was constructed as follows: The original building was constructed in 1957, is one-story, has a partial basement, is fully sprinklered and was determined to be of Type II (111) construction; In 1976 the basement shell space Addition was constructed. This addition is fully sprinklered and was determined to be of Type V(111) construction. The facility has smoke detection at smoke barrier doors and in spaces open to the corridor, which are monitored for automatic fire department notification. The facility has a capacity of 38 beds and had a census of 26 at time of the survey.	K 000		

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

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