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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PDZX
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 **10/04/2016** (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 **34** (L18)

13. Total Certified Beds **34** (L17)

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

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
	34			
(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
Gail Anderson, Unit Supervisor
Date: 10/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath, Enforcement Specialist
Date: 11/23/2016 (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.
00660
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/03/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245597

November 23, 2016

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 September 26, 2016 the above facility is certified for:

34 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 34 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 20, 2016

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

RE: Project Number S5597025

Dear Ms. Olson:

On September 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 18, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 4, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 13, 2016 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 August 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 18, 2016, effective September 26, 2016 and therefore remedies outlined in our letter to you dated September 2, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

An equal opportunity employer.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245597	A. Building B. Wing	10/4/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 09/26/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 09/26/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 09/26/2016
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 08/20/2016	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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GA/mm	10/20/2016	28034	10/04/2016
REVIEWED BY CMS RO	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
[ ]				

FOLLOWUP TO SURVEY COMPLETED ON
8/18/2016

[ ] 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245597 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	9/13/2016 (Y3)

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/09/2016	ID Prefix Reg. # NFPA 101 LSC K0075	Correction Completed 09/09/2016	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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	10/20/2016	36536	09/13/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/16/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PDZX
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 **08/18/2016** (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 **34** (L18)

13.Total Certified Beds **34** (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
	34			
(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 :
Sherri Softing, HFE NEII 09/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/03/2016 (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.
00660
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 2, 2016

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

RE: Project Number S5597025

Dear Ms. Olson:

On August 18, 2016, 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:

> 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140 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 September 27, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 27, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 18, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 18, 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.

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118   Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING ______ B. WING ______	08/18/2016

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. 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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a dignified dining experience for 2 of 2 residents (R2, R30) who required assistance with eating during the breakfast meal in the main dining room. Findings include: R2's quarterly Minimum Data Set(MDS), dated 5/24/6, identified R2 had diagnoses which included non Alzheimer dementia, psychotic disorder and Diabetes Mellitus and had severely impaired cognitive skills for daily decision making.	F 241	Corrective Action: The care plan for resident R2 was updated on 8-18-2016 to include the following: resident will sleep longer in the mornings she is not easily aroused, staff will attempt to wake her if she falls asleep at the table by gentle touch and calling her name. Once it is evident she is not going to awaken she will be returned to her room and attempts will be made periodically to assist her with a meal. Staff was informed via shift reports beginning on 8-17-2016 that sternal rubs are not acceptable.	9/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/09/2016

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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	245597	A. BUILDING ______ B. WING ______	08/18/2016

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 241

Continued From page 1

Further, R2's MDS identified R2 was totally dependent on staff for assistance with all activities of daily living, including eating.

During observation on 8/17/16, from 7:32 a.m. to 8:28 a.m. R2 was seated in a wheelchair at a table in the main dining room, R2's eye were closed with head down to her chest. Nursing assistant (NA)-B sat to the left of R2, and attempted to awaken R2 during the entire meal observation. NA-B put a cup of fluids up to R2's mouth, with the contents running out of her mouth and onto the clothing protector around R2's upper torso area. At 7:52 a.m. NA-B proceeded to use her closed fist and rubbed R2's chest bone (sternum) several times with her closed fist. NA-B repeatedly called out R2's first and last name, and stated wake up, wake up, wake up. R2 briefly scrunched up her face, and her eyes remained closed. At 7:54 a.m., NA-B repeated rubbing her closed fist on R2's chest bone, called out R2's name and stated to wake up. R2 did not open her eyes,lift her head or attempt to make noise. NA-B continued to attempt to feed R2 apple juice, milk, and oatmeal while R2 remained asleep in her chair. While NA-B attempted to pour the food and beverage items into R2's mouth, the contents repeatedly spilled out the sides of R2's mouth, onto the clothing protector.

During observation on 8/17/16, at 8:03 a.m. R30 was seated in a wheelchair at the same table next to R2, and was being assisted by the social service designee (SSD). At 8:03 a.m., NA-B stated "I don't know what is worse" being comatose with your mouth open with food in it or sleeping, we have two sleepy heads over here, its not fair.

F 241

Correction as it applies to other residents: On 9/7/16 all staff attended an in-service on the 5 areas of dignity; respecting care needs, maximizing the dining experience, living in the secured unit, participating in activities and respecting the residents room and personal space. All staff participated in an interactive activity of assisting each other with oral intake.
In addition, all staff training is scheduled to be held on 10/20/16 titled The Virtual Dementia Tour.

Reoccurrence will be prevented by: DON or designee will audit the dining room weekly x 4 then monthly for compliance.

DON will report audit findings to the QAPI committee on a quarterly basis for further direction.

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During interview on 8/17/16, at 9:00am. nursing assistant (NA)-B confirmed R2 was frequently sleepy during breakfast, and stated she had a very difficult time feeding R2. NA-B confirmed she attempted to give R2 fluids while R2 slept, and the fluids came directly back out of her mouth onto her clothing protector. NA-B also confirmed she used her fist to rub R2's chest to wake her and stimulate her, without causing her pain to try to get her coherent enough to push the fluids, and confirmed it was common practice in the facility to do this technique. NA-B reported she had been directed to use the chest rub as an intervention to stimulate R2. NA indicated she felt this was not a dignified way to assist R2 to eat breakfast.

During interview on 8/17/16, at 9:32 a.m. nursing assistant (NA)-A reported R2 was usually tired during meals, and confirmed she had in the past used the chest rub on R2 to stimulate her to eat or drink during meals. NA-A reported the chest rub was not to be used repeatedly, and staff should not be giving fluids or foods by mouth if R2 was not opening her mouth.

During interview on 8/17/16, at 9:56 a.m. social service designee (SSD) reported R2 was generally tired during breakfast and confirmed using sternal rubs and continuing to feed R2 while sleeping was not a dignified dining experience, or was it facility practice.

During interview on 8/17/16, at 10:02 a.m., the director of nursing confirmed all residents need to be awake prior to being fed, both food and fluids. The DON confirmed it was not appropriate to use sternal rubs to stimulate R2, and stated she would have stopped that if she would have seen that being done. The DON verified the

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F 241	Continued From page 3 statements made at the dining table by the NA and the manner R2 was assisted was not a dignified dining experience. The DON confirmed all staff in the past had received education on how to treat resident with dementia and cognitive impairments. The facility's Quality of Life-Dignity policy, dated August 2009 indicated each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect and individuality. Further, the policy indicated the staff shall treat cognitively impaired residents with dignity and sensitivity.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance as directed by the individualized care plan for 1 of 3 resident (R28) who required staff assistance for activities of daily living (ADLs). Finding include: R28's care plan, revised on 7/21/16, identified R28 had impaired cognition, had communication problem and ADL self-care deficit related to Alzheimer's disease. The care plan listed various interventions which included for staff to ask	F 282	Corrective Action: Resident R28 facial hair was removed on 8/18/2016. Her care plan was updated to include removal of facial hair weekly with tub bath and prn. Correction as it applies to other residents: All staff attended an education session on 9/7/16 which included providing ADL care to all dependent residents per their plan of care. Care plans for all current residents were reviewed and updated, if needed regarding removal of facial hair on or before 9/26/16.	9/26/16

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F 282	Continued From page 4 yes/no questions to determine needs, anticipate and meet needs, and to assist R28 with personal hygiene, dressing and oral care. During observation on 8/15/16 at 7:30 p.m. R28 was noted to have many white/black, coarse facial hairs on her upper lip which extended over her lip area and onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer. On 8/16/16 at 9:19 a.m. R28 was noted to have white/black, coarse facial hair on her upper lip which extended over her lip area and onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer. On 8/17/16, at 7:56 a.m., R28 was in the dining room eating breakfast. R28 was again observed to have white/black, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer. At 9:45 a.m. R28 was seated in her wheelchair in her room. R28 continued to have black/ white, long, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area. At 10:00 a.m. R28 was seated in her wheelchair in the dining room across from the nurse's station, playing ball with several other residents. R28 continued to have black/ white, long, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area. On 8/18/16, at 9:15 a.m., R28 was seated in the	F 282	Reoccurrence will be prevented by: DON or designee will audit the timely completion of ADL care weekly x 4 then monthly for compliance. DON will report audit findings to the QAPI committee on a quarterly basis for further direction.	

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F 282	Continued From page 5 dining room eating breakfast. R28 continued to have black/ white, thick, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area. R28 ' s facial hairs were approximately 1/4 inch or longer. At 1:30 p.m. R28's facial hair was observed to remain the same. On 8/18/16 at 9:25 a.m. NA-D confirmed staff routinely assisted R28 with ADL ' s and indicated R28 required extensive assistance from staff for personal hygiene. NA-D also indicated R28 usually gets shaved on her bath day and if she had time she would go around and shave other female residents. NA-D verified R28 had a lot of coarse facial hair and indicated that it should be on her care plan to get shaved more than once a week. On 8/18/16 at 10:38 p.m. director of nursing (DON) confirmed R28's current care plan and indicated R28 required assistance with grooming. DON indicated her expectation of staff would be to provide the residents with a razor and to remove their hair on their bath days or when needed. DON indicated she felt staff could make the decision on whether facial hair needed to be removed or not and stated "We need to look out for her best interest." Review of the facility policy titled, Using The Care Plan, revised 8/2006 indicated the care plan shall be used in developing the residents daily care routines and will be available to staff personnel who have responsibility for providing care or services to the residents.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		9/26/16

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A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document interview, the facility failed to provide shaving assistance for 1 of 3 residents (R28) who required assistance with grooming.

Findings include:

R28's annual Minimum Data Set (MDS) dated 7/18/16, indicated R28 had diagnoses which included: Alzheimer's disease, depression and heart failure. The MDS identified R28 was severely cognitively impaired and required extensive assistance of one staff member for personal hygiene, dressing, toileting, and bathing.

R28's care plan, revised on 7/21/16, identified R28 had impaired cognition, had communication problem and activities of daily living (ADL) self-care deficit related to Alzheimer ' s disease. The care plan listed various interventions which included for staff to ask yes/no questions to determine needs, anticipate and meet needs, and to assist R28 with personal hygiene, dressing and oral care.

During observation on 8/15/16 at 7:30 p.m. R28 was noted to have many white/black, coarse facial hairs on her upper lip which extended over her lip area and onto her entire chin and under

Corrective Action: Resident R28 facial hair was removed on 8/18/2016. Her care plan was updated to include total assist of 1 to remove facial hair weekly with tub bath and prn.

Correction as it applies to other residents: All staff attended an education session on 9/7/16 which included providing ADL care (including the removal of facial hair) to all dependent residents per their plan of care. Care plans for all current residents were reviewed and updated, if needed regarding ADL care on or before 9/26/16.

Reoccurrence will be prevented by: DON or designee will audit the timely completion of ADL care weekly x 4 then monthly for compliance.

DON will report audit findings to the QAPI committee on a quarterly basis for further direction.

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her chin. The facial hairs were approximately 1/4 inch or longer.

On 8/16/16 at 9:19 a.m. R28 was noted to have white/black, coarse facial hair on her upper lip which extended over her lip area and onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer.

On 8/17/16, at 7:56 a.m., R28 was in the dining room eating breakfast. R28 was again observed to have white/black, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer.

At 9:45 a.m. R28 was seated in her wheelchair in her room. R28 continued to have black/ white, long, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area.

At 10:00 a.m. R28 was seated in her wheelchair in the dining room across from the nurse's station, playing ball with several other residents. R28 continued to have black/ white, long, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area.

On 8/18/16, at 9:15 a.m., R28 was seated in the dining room eating breakfast. R28 continued to have black/ white, thick, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area. R28 ' s facial hairs were approximately 1/4 inch or longer. At 1:30 p.m. R28's facial hair was observed to remain the same.

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F 312	Continued From page 8 On 8/18/16 at 9:08 a.m. nursing assistant (NA)-C confirmed staff routinely assisted R28 with activities of daily living (ADL ' s) and indicated R28 required extensive assistance from staff for personal hygiene. NA-C indicated staff would assist R28 with shaving when they had time but do not always have the time to shave R28. NA-C indicated she felt R28's face would be shaved with her routine weekly bath. On 8/18/16 at 9:25 a.m. NA-D confirmed staff routinely assisted R28 with ADL's and indicated R28 required extensive assistance from staff for personal hygiene. NA-D also indicated R28 usually gets shaved on her bath day and if she had time she would go around and shave other female residents. NA-D verified R28 had a lot of coarse facial hair and indicated that it should be on her care plan to get shaved more than once a week. On 8/18/16 at 10:25 a.m. registered nurse (RN)-B confirmed staff routinely assisted R28 with ADL ' s and R26 required extensive assistance from staff for personal hygiene. RN-B indicated R28 was to have her bath today and stated " the girls should be shaving on bath days and when needed." RN-B indicated it was not dignified to have facial hair and stated " it should be taken care of. " On 8/18/16 at 10:38 p.m. director of nursing (DON) confirmed R28's current care plan and indicated R28 required assistance with grooming. DON indicated her expectation of staff would be to provide the residents with a razor and to remove their hair on their bath days or when needed. DON indicated she felt staff could make the decision on whether facial hair needed to be	F 312		

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F 312	Continued From page 9 removed or not and stated "We need to look out for her best interest." Review of the facility policy titled, Using The Care Plan, revised 8/2006 indicated the care plan shall be used in developing the residents daily care routines and will be available to staff personnel who have responsibility for providing care or services to the residents.	F 312		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		8/20/16

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F 431	Continued From page 10 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for accurate accounting of controlled medications in 1 of 1 emergency kit (E-Kit) utilized in the facility. This deficient practice had the potential to affect any resident who might require the medication from the E-kit. Findings include: On 8/17/16 at 1:01 p.m. the medication storage room tour was conducted with registered nurse (RN)-B. A green, plastic box was observed in the medication room refrigerator, which facility staff identified as a refrigerated emergency stock medication box (E-kit) for the facility. This refrigerated E-kit had a red plastic strip attached to the clasp. The red plastic strip had the number 4198551 on the tab of the strip. RN-B opened the E-kit, and 10 vials of lorazepam (anti-anxiety medication, controlled substance) were observed to be stored in the refrigerated E-kit. Review of the facility form titled E-Kit Lock Replacement Sign Out Sheet revealed the red plastic strip on the refrigerated E-kit box, which contained lorazapem, had last been changed on 6/5/16, and indicated the replacement red plastic strip with number 0004363 had been applied.	F 431	Corrective Action: The refrigerated E kit was reconciled as correct on 8/18/2016. The procedure was reviewed with the supplying pharmacy and the consultant pharmacist on 8/18/2016. The procedure to verify entry into the locked kit was updated and explained to all nurses via the shift report and email to all nurses. The form used to record entry/tag numbers was updated and added to the refrigerated kit. The tags are now only available in a limited number and in sequence. Correction as it applies ongoing: Charge nurses will check the tags daily with narcotic stock count. Reoccurrence will be prevented by: DON or designee will audit the entry form weekly x 4 then monthly for compliance. Consultant pharmacist will audit the entry form monthly x 3 for compliance. DON will report audit findings to the QAPI committee on a quarterly basis for further direction.	

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However, the form lacked documentation of any additional change of the red plastic strip for the refrigerated E-kit, and any ongoing monitoring of the security strip/lock to prevent potential loss or diversion of the medication.

After the surveyor had identified the red plastic strip lock numbers were different than what had been documented, RN-B removed the red plastic strip/lock and confirmed the contents of the E-kit. RN-B then placed a new red plastic strip lock numbered 4198504, and notified the pharmacy of the findings. RN-B confirmed the last documented time the red plastic lock had been changed was recorded as 6/5/16. RN-B verified the red plastic lock to secure the E-Kit, should have been numbered as documented.. She stated she was "not sure when the last time the tag was changed." RN-B indicated the usual facility practice was for licensed staff to visually check the red plastic lock/security numbers on both refrigerated and non refrigerated E-kits at least daily, but stated the facility did not have a process of documentation for such checks.

On 8/18/16 at approximately 1:30 p.m. RN-B stated she'd spoken with the facility's consultant pharmacist who stated she'd replaced the lorazepam in the E-Kit on 8/1/16 and had not recorded the new red red plastic strip lock number after having removed the old one, nor could the pharmacist remember which numbered red plastic strip she'd removed from the refrigerated E-Kit at that time. RN-B also stated she was not sure whether that was the only time the E-Kit red plastic strip had been removed or replaced since 6/5/16, and indicated staff should be checking the red plastic strip routinely with medication verification.

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 ______	08/18/2016

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

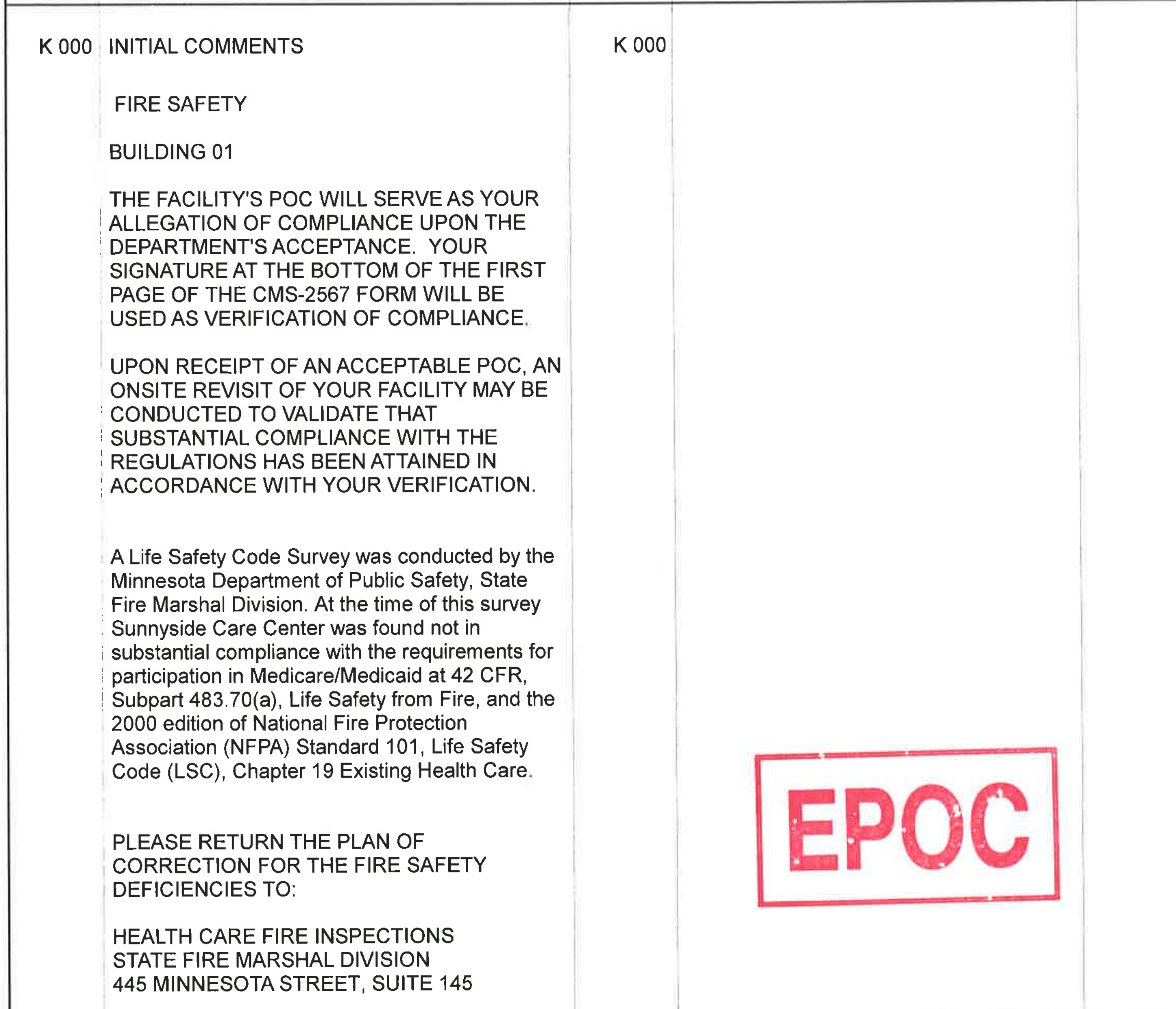
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 On 8/18/16 at 10:41 a.m., the director of nursing (DON) confirmed the findings and verified each time the red plastic strip was removed, staff should have documented the access and removal or replacement of any medication. The DON also stated the pharmacist had been at the facility today and stated, "she was the one that did it and did not record the tag on the sheet." The DON also stated the pharmacist made an entry on the E-Kit sign out sheet and stated staff should be checking the red plastic strip routinely with medication verification. A facility policy for E-kit procedures was requested on 8/19/16, however none was provided.	F 431		

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

F5597025

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 ____	**08/16/2016**

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
K 000	INITIAL COMMENTS FIRE SAFETY BUILDING 01 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Sunnyside Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/09/2016

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/16/2016

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
K 000	Continued From page 1	K 000		

ST. PAUL, MN 55101-5145, or

Or by email to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

This facility was surveyed as two building:
The Sunnyside Care Center is a 1-story building without a basement built at two different time. The original building was constructed in 1975 and is of Type II(00) construction. In 2004 an entrance and dayroom additions were constructed to the north and south sides of the 1975 building and were determined to be of Type V (111) construction.

The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification.

The facility has a capacity of 34 beds and had a

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 ______	**08/16/2016**

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
K 000	Continued From page 2 census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff inteview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99),This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 1 of the 28 residents and an udetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 12:00 pm on 08/16/2016 observations and staff interview revealed items in the closet of resident room 113 were stored less than 18 inches below the sprinkler deflector. This deficient practice was verified by the Facility Administrator and the Maintenance Supervisor.	K 062	Items in closet of room 113 were removed on 9/9/2016 ensuring there is now 18" of space below the sprinkler deflector. Staff were educated via Total Quality Management (TQM) communication on 9/9/2016 regarding the requirement to keep 18" of space below sprinkler deflectors. Responsible Party: Maintenance Supervisor	9/9/16
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 075		9/9/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/16/2016**

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
K 075	Continued From page 3 Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents and an undetermined amount of staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On the facility tour between 8:15 am to 12:00 pm on 08/16/2016 observations and staff interview revealed linen containers that exceed 32 gallons being stored in the alcoves of the east and west resident wings. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 075	On 9/9/2016 one (1) bin of soiled linen was removed from each alcove. The remaining bin in each alcove does not exceed 32 gallons in capacity. Staff were educated via Total Quality Management (TQM) communication on 9/9/2016 of the requirement and subsequent changes to the practice of soiled linen storage. Responsible Party: Maintenance Supervisor	

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

F5597025

PRINTED: 09/12/2016
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 02 - ADMINISTRATION ADDITION B. WING ______	08/16/2016

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
K 000	INITIAL COMMENTS	K 000		

Fire Safety

Building 02

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Sunnyside Care Center 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 Facilities.

This facility was surveyed as two building:
The Sunnyside Care Center is a 1-story building without a basement built at two different time. The original building was constructed in 1975 and is of Type II(00) construction. In 2004 an entrance and dayroom additions were constructed to the north and south sides of the 1975 building and were determined to be of Type V (111) construction.

The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification.

The facility has a capacity of 34 beds and had a census of 28 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 09/09/2016

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING **02 - ADMINISTRATION ADDITION** B. WING	**08/16/2016**

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 2, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5597025

Dear Ms. Olson:

The above facility was surveyed on August 15, 2016 through August 18, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00016	A. BUILDING: ______ B. WING ______	08/18/2016

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) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00016	A. BUILDING: ______ B. WING ______	08/18/2016

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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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On 8/15-18/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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	00016	A. BUILDING: ______ B. WING ______	08/18/2016

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance as directed by the individualized care plan for 1 of 3 resident (R28) who required staff assistance for activities of daily living (ADLs). Finding include: R28's care plan, revised on 7/21/16, identified R28 had impaired cognition, had communication problem and ADL self-care deficit related to Alzheimer's disease. The care plan listed various interventions which included for staff to ask yes/no questions to determine needs, anticipate and meet needs, and to assist R28 with personal hygiene, dressing and oral care. During observation on 8/15/16 at 7:30 p.m. R28 was noted to have many white/black, coarse facial hairs on her upper lip which extended over her lip area and onto her entire chin and under her chin. The facial hairs were approximately 1/4	2 565	Corrected	9/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00016	A. BUILDING: ______ B. WING ______	08/18/2016

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2 565	Continued From page 3	2 565		

inch or longer.

On 8/16/16 at 9:19 a.m. R28 was noted to have white/black, coarse facial hair on her upper lip which extended over her lip area and onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer.

On 8/17/16, at 7:56 a.m., R28 was in the dining room eating breakfast. R28 was again observed to have white/black, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer.

At 9:45 a.m. R28 was seated in her wheelchair in her room. R28 continued to have black/ white, long, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area.

At 10:00 a.m. R28 was seated in her wheelchair in the dining room across from the nurse's station, playing ball with several other residents. R28 continued to have black/ white, long, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area.

On 8/18/16, at 9:15 a.m., R28 was seated in the dining room eating breakfast. R28 continued to have black/ white, thick, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area. R28 ' s facial hairs were approximately 1/4 inch or longer. At 1:30 p.m. R28's facial hair was observed to remain the same.

On 8/18/16 at 9:25 a.m. NA-D confirmed staff routinely assisted R28 with ADL ' s and indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00016	A. BUILDING: ______ B. WING ______	08/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4	2 565		

R28 required extensive assistance from staff for personal hygiene. NA-D also indicated R28 usually gets shaved on her bath day and if she had time she would go around and shave other female residents. NA-D verified R28 had a lot of coarse facial hair and indicated that it should be on her care plan to get shaved more than once a week.

On 8/18/16 at 10:38 p.m. director of nursing (DON) confirmed R28's current care plan and indicated R28 required assistance with grooming. DON indicated her expectation of staff would be to provide the residents with a razor and to remove their hair on their bath days or when needed. DON indicated she felt staff could make the decision on whether facial hair needed to be removed or not and stated "We need to look out for her best interest."

Review of the facility policy titled, Using The Care Plan, revised 8/2006 indicated the care plan shall be used in developing the residents daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff implement resident care plans. The quality assessment and assurance committee could perform random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty (21) days.

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2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs	2 920		9/26/16

Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:
B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document interview, the facility failed to provide shaving assistance for 1 of 3 residents (R28) who required assistance with grooming.

Corrected

Findings include:

R28's annual Minimum Data Set (MDS) dated 7/18/16, indicated R28 had diagnoses which included: Alzheimer's disease, depression and heart failure. The MDS identified R28 was severely cognitively impaired and required extensive assistance of one staff member for personal hygiene, dressing, toileting, and bathing.

R28's care plan, revised on 7/21/16, identified R28 had impaired cognition, had communication problem and activities of daily living (ADL) self-care deficit related to Alzheimer ' s disease. The care plan listed various interventions which included for staff to ask yes/no questions to determine needs, anticipate and meet needs, and to assist R28 with personal hygiene, dressing and oral care.

During observation on 8/15/16 at 7:30 p.m. R28 was noted to have many white/black, coarse

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2 920	Continued From page 6	2 920		

facial hairs on her upper lip which extended over her lip area and onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer.

On 8/16/16 at 9:19 a.m. R28 was noted to have white/black, coarse facial hair on her upper lip which extended over her lip area and onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer.

On 8/17/16, at 7:56 a.m., R28 was in the dining room eating breakfast. R28 was again observed to have white/black, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin. The facial hairs were approximately 1/4 inch or longer.

At 9:45 a.m. R28 was seated in her wheelchair in her room. R28 continued to have black/ white, long, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area.

At 10:00 a.m. R28 was seated in her wheelchair in the dining room across from the nurse's station, playing ball with several other residents. R28 continued to have black/ white, long, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area.

On 8/18/16, at 9:15 a.m., R28 was seated in the dining room eating breakfast. R28 continued to have black/ white, thick, coarse facial hair on her upper lip which extended over her lip area, onto her entire chin and under her chin area. R28 ' s facial hairs were approximately 1/4 inch or longer. At 1:30 p.m. R28's facial hair was observed to remain the same.

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2 920	Continued From page 7 On 8/18/16 at 9:08 a.m. nursing assistant (NA)-C confirmed staff routinely assisted R28 with activities of daily living (ADL ' s) and indicated R28 required extensive assistance from staff for personal hygiene. NA-C indicated staff would assist R28 with shaving when they had time but do not always have the time to shave R28. NA-C indicated she felt R28's face would be shaved with her routine weekly bath. On 8/18/16 at 9:25 a.m. NA-D confirmed staff routinely assisted R28 with ADL's and indicated R28 required extensive assistance from staff for personal hygiene. NA-D also indicated R28 usually gets shaved on her bath day and if she had time she would go around and shave other female residents. NA-D verified R28 had a lot of coarse facial hair and indicated that it should be on her care plan to get shaved more than once a week. On 8/18/16 at 10:25 a.m. registered nurse (RN)-B confirmed staff routinely assisted R28 with ADL ' s and R26 required extensive assistance from staff for personal hygiene. RN-B indicated R28 was to have her bath today and stated " the girls should be shaving on bath days and when needed." RN-B indicated it was not dignified to have facial hair and stated " it should be taken care of. " On 8/18/16 at 10:38 p.m. director of nursing (DON) confirmed R28's current care plan and indicated R28 required assistance with grooming. DON indicated her expectation of staff would be to provide the residents with a razor and to remove their hair on their bath days or when needed. DON indicated she felt staff could make the decision on whether facial hair needed to be	2 920		

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2 920	Continued From page 8 removed or not and stated "We need to look out for her best interest." Review of the facility policy titled, Using The Care Plan, revised 8/2006 indicated the care plan shall be used in developing the residents daily care routines and will be available to staff personnel who have responsibility for providing care or services to the residents. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff perform acitivites of daily living according to resident care plans. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 920		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for accurate accounting of controlled medications in	21610	Corrected	8/20/16

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1 of 1 emergency kit (E-Kit) utilized in the facility.

Findings include:

On 8/17/16 at 1:01 p.m. the medication storage room tour was conducted with registered nurse (RN)-B. A green, plastic box was observed in the medication room refrigerator, which facility staff identified as a refrigerated emergency stock medication box (E-kit) for the facility. This refrigerated E-kit had a red plastic strip attached to the clasp. The red plastic strip had the number 4198551 on the tab of the strip. RN-B opened the E-kit, and 10 vials of lorazepam (anti-anxiety medication, controlled substance) were observed to be stored in the refrigerated E-kit.

Review of the facility form titled E-Kit Lock Replacement Sign Out Sheet revealed the red plastic strip on the refrigerated E-kit box, which contained lorazapem, had last been changed on 6/5/16, and indicated the replacement red plastic strip with number 0004363 had been applied. However, the form lacked documentation of any additional change of the red plastic strip for the refrigerated E-kit, and any ongoing monitoring of the security strip/lock to prevent potential loss or diversion of the medication.

After the surveyor had identified the red plastic strip lock numbers were different than what had been documented, RN-B removed the red plastic strip/lock and confirmed the contents of the E-kit. RN-B then placed a new red plastic strip lock numbered 4198504, and notified the pharmacy of the findings. RN-B confirmed the last documented time the red plastic lock had been changed was recorded as 6/5/16. RN-B verified the red plastic lock to secure the E-Kit, should have been numbered as documented.. She

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stated she was "not sure when the last time the tag was changed." RN-B indicated the usual facility practice was for licensed staff to visually check the red plastic lock/security numbers on both refrigerated and non refrigerated E-kits at least daily, but stated the facility did not have a process of documentation for such checks.

On 8/18/16 at approximately 1:30 p.m. RN-B stated she'd spoken with the facility's consultant pharmacist who stated she'd replaced the lorazepam in the E-Kit on 8/1/16 and had not recorded the new red red plastic strip lock number after having removed the old one, nor could the pharmacist remember which numbered red plastic strip she'd removed from the refrigerated E-Kit at that time. RN-B also stated she was not sure whether that was the only time the E-Kit red plastic strip had been removed or replaced since 6/5/16, and indicated staff should be checking the red plastic strip routinely with medication verification.

On 8/18/16 at 10:41 a.m., the director of nursing (DON) confirmed the findings and verified each time the red plastic strip was removed, staff should have documented the access and removal or replacement of any medication. The DON also stated the pharmacist had been at the facility today and stated, "she was the one that did it and did not record the tag on the sheet." The DON also stated the pharmacist made an entry on the E-Kit sign out sheet and stated staff should be checking the red plastic strip routinely with medication verification.

A facility policy for E-kit procedures was requested on 8/19/16, however none was provided.

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21610	Continued From page 11 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring medication reconcilliation of e-kit medications is maintained. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21610		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a dignified dining experience for 2 of 2 residents (R2, R30) who required assistance with eating during the breakfast meal in the main dining room. Findings include: R2's quarterly Minimum Data Set(MDS), dated 5/24/6, identified R2 had diagnoses which included non Alzheimer dementia, psychotic disorder and Diabetes Mellitus and had severely impaired cognitive skills for daily decision making. Further, R2's MDS identified R2 was totally dependent on staff for assistance with all activities of daily living, including eating.	21805	Corrected	9/26/16

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During observation on 8/17/16, from 7:32 a.m. to 8:28 a.m. R2 was seated in a wheelchair at a table in the main dining room, R2's eye were closed with head down to her chest. Nursing assistant (NA)-B sat to the left of R2, and attempted to awaken R2 during the entire meal observation. NA-B put a cup of fluids up to R2's mouth, with the contents running out of her mouth and onto the clothing protector around R2's upper torso area. At 7:52 a.m. NA-B proceeded to use her closed fist and rubbed R2's chest bone (sternum) several times with her closed fist. NA-B repeatedly called out R2's first and last name, and stated wake up, wake up, wake up. R2 briefly scrunched up her face, and her eyes remained closed. At 7:54 a.m., NA-B repeated rubbing her closed fist on R2's chest bone, called out R2's name and stated to wake up. R2 did not open her eyes,lift her head or attempt to make noise. NA-B continued to attempt to feed R2 apple juice, milk, and oatmeal while R2 remained asleep in her chair. While NA-B attempted to pour the food and beverage items into R2's mouth, the contents repeatedly spilled out the sides of R2's mouth, onto the clothing protector.

During observation on 8/17/16, at 8:03 a.m. R30 was seated in a wheelchair at the same table next to R2, and was being assisted by the social service designee (SSD). At 8:03 a.m., NA-B stated "I don't know what is worse" being comatose with your mouth open with food in it or sleeping, we have two sleepy heads over here, its not fair.

During interview on 8/17/16, at 9:00am. nursing assistant (NA)-B confirmed R2 was frequently sleepy during breakfast, and stated she had a very difficult time feeding R2. NA-B confirmed she

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21805	Continued From page 13 attempted to give R2 fluids while R2 slept, and the fluids came directly back out of her mouth onto her clothing protector. NA-B also confirmed she used her fist to rub R2's chest to wake her and stimulate her, without causing her pain to try to get her coherent enough to push the fluids, and confirmed it was common practice in the facility to do this technique. NA-B reported she had been directed to use the chest rub as an intervention to stimulate R2. NA indicated she felt this was not a dignified way to assist R2 to eat breakfast. During interview on 8/17/16, at 9:32 a.m. nursing assistant (NA)-A reported R2 was usually tired during meals, and confirmed she had in the past used the chest rub on R2 to stimulate her to eat or drink during meals. NA-A reported the chest rub was not to be used repeatedly, and staff should not be giving fluids or foods by mouth if R2 was not opening her mouth. During interview on 8/17/16, at 9:56 a.m. social service designee (SSD) reported R2 was generally tired during breakfast and confirmed using sternal rubs and continuing to feed R2 while sleeping was not a dignified dining experience, or was it facility practice. During interview on 8/17/16, at 10:02 a.m., the director of nursing confirmed all residents need to be awake prior to being fed, both food and fluids. The DON confirmed it was not appropriate to use sternal rubs to stimulate R2, and stated she would have stopped that if she would have seen that being done. The DON verified the statements made at the dining table by the NA and the manner R2 was assisted was not a dignified dining experience. The DON confirmed all staff in the past had received education on how to treat resident with dementia and cognitive	21805		

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impairments.

The facility's Quality of Life-Dignity policy, dated August 2009 indicated each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect and individuality. Further, the policy indicated the staff shall treat cognitively impaired residents with dignity and sensitivity.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures dignified dining expereience. The quality assessment and assurance committee could perform random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty (21) days.