#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

		AKE/MEDICAL TO BE COMPI							PDZX cility ID: 00016	
1. MEDICARE/MEDICAID PROVID (L1) 245597 2.STATE VENDOR OR MEDICAID (L2) 863840300		3. NAME AND AL (L3) SUNNYSIDI (L4) 16561 US HI (L5) LAKE PARI	E CARE CEN IGHWAY 10		(L6) 5	56554	1. Initial 3. Termin 5. Validat	ion	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 10/0	OWNERSHIP 4/2016 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	JPPLIER CATEC  05 HHA  06 PRTF	GORY 09 ESRD 10 NF	02 (L7) 13 PTIP 14 CORF	22 CLIA		rvey After Co		
8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE		FISCAL YEA		EDATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b):		Compliance		AS:	2. Techi	nical Personnel	7. M	Requirements ope of Servi edical Directient Room S	ces Limit	
12.Total Facility Beds 13.Total Certified Beds	34 (L18) 34 (L17)	B. Not in Comp	liance with Progr and/or Applied		5. Life \$	Safety Code	9. Be	eds/Room		
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 34	OWN 19 SNF	ICF	IID		15. FACILITY M 1861 (e) (1) or		(L	15)		
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY	APPROVAL		Date:	
Gail Anderson, Uni	t Supervisor	1	0/20/2016	(L19)	Mark-	Meath	, Enforcemer	nt Specialis		.20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR	SINGLE S'	TATE AGE	NCY		
<ul> <li>19. DETERMINATION OF ELIGIBI</li> <li>_X 1. Facility is Eligible to</li> <li> 2. Facility is not Eligible</li> </ul>	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	2. O		icial Solvency (Fi I Interest Disclos :		CFA-1513)	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINAT	TON ACTION:		(L3	0)	
OF PARTICIPATION 02/01/1992	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closu		<u> </u>	NVOLUNTA 5-Fail to Me	ARY et Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction			6-Fail to Me	et Agreement	
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS  n of Admissions:  uspension Date:	(L44)		03-Risk of Involut 04-Other Reason	=	0	OTHER 7-Provider S 0-Active	Status Change	
	D. 1000mu 00	opension Bute.	(L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS					
	(L28)	00660		(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	DATE						

(L33)

DETERMINATION APPROVAL

10/03/2016

(L32)



#### 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 Weath

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 Weath

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

**ID Prefix** 

Reg. #

**ID Prefix** 

LSC

F0431

483.60(b), (d), (e)

Correction

Completed

08/20/2016

Correction

**ID Prefix** 

Reg. #

LSC

**ID Prefix** 

		POST	-CERT	TIFICATION	N REVISIT RI	EPORT	-		
	R / SUPPLIER / CLIA /	MULTIPLE CONS	STRUCTION					DATE OF REV	ISIT
1DENTIFIC 245597	CATION NUMBER	A. Building B. Wing						10/4/2016	
240097		Y1 B. Willig					Y2	10/4/2010	Y3
NAME OF	FACILITY				STREET ADDRESS, CIT	Y, STATE, ZII	PCODE		
SUNNYS	SIDE CARE CENTER				16561 US HIGHWAY 10				
					LAKE PARK, MN 56554				
	ey report form).	DATE	ITEM		.2567 (prefix codes show	ITEM		DAT	
Y4		Y5	Y4		Y5	Y4		Y	5
ID Prefix	F0241	Correction	ID Prefix	F0282	Correction	ID Prefix	F0312	Corr	ection
Reg.#	483.15(a)	Completed	Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25(a)(3)	Com	pleted
LSC		09/26/2016	LSC		09/26/2016	LSC		09/26	3/2016

Correction

Completed

Correction

**ID Prefix** 

Reg.#

**ID Prefix** 

LSC

Correction

Completed

Correction

### POST-CERTIFICATION REVISIT REPORT

PROVIDE	R / SUPPLIER / C	LIA / MULTIPLE CONS			TILL VIOIT ILL	-1 01(1		DATE O	F REVISIT
IDENTIFIC	CATION NUMBER	A. Building 01	MAIN BUILDING	01					
245597		Y1 B. Wing			1		Y2	9/13/20	16 <sub>Y3</sub>
	FACILITY	ITED			STREET ADDRESS, CIT	Y, STATE, ZIP CO	ODE		
SUNNYS	IDE CARE CEN	IIER			16561 US HIGHWAY 10 LAKE PARK, MN 56554				
					1				
program, corrected provision	to show those of	by a qualified State survey deficiencies previously repouch corrective action was a de identification prefix code p	orted on the CMS-2 ccomplished. Eac	2567, Staten h deficiency	ment of Deficiencies and should be fully identifie	Plan of Correct dusing either the	tion, that have he regulation o	r LSC	
ITE	М	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	101	Completed	Reg. #			Completed
LSC	K0062	09/09/2016	LSC K0075	5	09/09/2016	LSC _			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC _			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix —			Correction
Reg.#		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC			LSC _			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix —			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
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Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC _			
REVIEWE		REVIEWED BY	DATE	SIGNATUR	RE OF SURVEYOR			DATE	
STATE AG	SENCY X	(INITIALS) TL/mm	10/20/2016		36	5536		09/13	3/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	

8/16/2016

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PDZX
Facility ID: 00016

	PARI I -	TO BE COMPI	LEIEDBY	THE STAI	IE SURVEY AGENCY		Facility ID: 00016
1. MEDICARE/MEDICAID PROVIE (L1) 245597 2.STATE VENDOR OR MEDICAID (L2) 863840300		3. NAME AND AI (L3) SUNNYSID (L4) 16561 US HI (L5) LAKE PARI	E CARE CEN IGHWAY 10		(L6) <b>56554</b>	4. TYPE OF ACT  1. Initial  3. Termination  5. Validation	CION: 2 (L8)  2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU		GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other
6. DATE OF SURVEY 08/1  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>8/2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	DING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds	34 (L18) 34 (L17)	Complianc 1. A  X B. Not in Con	ance With equirements e Based On: acceptable POC	ogram	And/Or Approved Waivers Of  2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code  * Code: B*	el 6. Scope of 7. Medical	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 34	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Sherri Softing, HFE N	NEII		09/22/2016	(L19)	Mark Meath	, Enforcement Spe	<u>cialist</u> 10/03/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA R	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBI      X_ 1. Facility is Eligible to     2. Facility is not Eligible	Participate		IPLIANCE WIT HTS ACT:	TH CIVIL	21. 1. Statement of Fine 2. Ownership/Contr 3. Both of the Abov	rol Interest Disclosure St	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	1:	(L30)
OF PARTICIPATION 02/01/1992	BEGINNING	G DATE	ENDING DA	ATE	VOLUNTARY 01-Merger, Closure	111101	UNTARY to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	A. Suspension	VE SANCTIONS n of Admissions: uspension Date:	(L25) (L44) (L45)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	ion <u>OTHE</u> F	vider Status Change
28. TERMINATION DATE:	29	). INTERMEDIARY	CARRIER NO.		30. REMARKS		
	(L28)	00660		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVA	L DATE			
	(L32)			(L33)	DETERMINATION APP	PROVAL	



#### 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:

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

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

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

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

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

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

#### **DEPARTMENT CONTACT**

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

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:

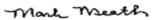
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

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

PRINTED: 09/22/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		245597	B. WING		8/18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC 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		of correction (POC) will serve	F 000		
	Department's accepenrolled in ePOC, yat the bottom of the	of compliance upon the obtance. Because you are your signature is not required it first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 241 SS=D	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 241 483.15(a) DIGNITY AND RESPECT OF		F 24	1	9/26/16
	The facility must promanner and in an eenhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observatoreview the facility fadining experience for who required assist breakfast meal in the Findings include: R2's quarterly Minimal Size of the facility of t	ition, interview, and document alled to ensure a dignified or 2 of 2 residents (R2, R30) tance with eating during the ne main dining room.  The mum Data Set(MDS), dated 2 had diagnoses which mer dementia, psychotic tes Mellitus and had severely skills for daily decision making.		Corrective Action: The care plan for resident R2 was updated on 8-18-2016 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 attempt will be made periodically to assist her will a meal. Staff was informed via shift reports beginning on 8-17-2016 that sternal rubs are not acceptable.	s

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY PLETED
		245597	B. WING		08/	18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 241	Further, R2's MDS dependent on staff activities of daily liv  During observation 8:28 a.m. R2 was stable in the main diclosed with head do assistant (NA)-B sattempted to awake observation. NA-B mouth, with the corand onto the clothir torso area. At 7:52 her closed fist and (sternum) several tirepeatedly called or and stated wake upscrunched up her faclosed. At 7:54 a.m. closed fist on R2's oname and stated to eyes, lift her head on continued to attem and oatmeal while I chair. While NA-B abeverage items into repeatedly spilled on onto the clothing property on the clothing property of the c	identified R2 was totally for assistance with all ing, including eating.  on 8/17/16, from 7:32 a.m. to eated in a wheelchair at a ning room, R2's eye were own to her chest. Nursing it to the left of R2, and en R2 during the entire meal put a cup of fluids up to R2's itents running out of her mouthing protector around R2's upper a.m. NA-B proceeded to use rubbed R2's chest bone mes with her closed fist. NA-B at R2's first and last name, a, wake up, wake up. R2 briefly ace, and her eyes remained, NA-B repeated rubbing her chest bone, called out R2's wake up. R2 did not open her attempt to make noise. NA-B pt to feed R2 apple juice, milk, R2 remained asleep in her attempted to pour the food and a R2's mouth, the contents ut the sides of R2's mouth,	F 2	Correction as it applies to other r On 9/7/16 all staff attended an in on the 5 areas of dignity; respect needs, maximizing the dining ex living in the secured unit, particip activities and respecting the resi room and personal space. All st participated in an interactive activ assisting each other with oral inta In addition, all staff training is sol to be held on 10/20/16 titled The Dementia Tour.  Reoccurrence will be prevented or designee will audit the dining i weekly x 4 then monthly for com  DON will report audit findings to committee on a quarterly basis for direction.	-service ing care perience, ating in dents   aff vity of ake. heduled Virtual  by: DON oom oliance.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245597	B. WING		08	/18/2016	
	PROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP ( 16561 US HIGHWAY 10 LAKE PARK, MN 56554			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 241	During interview of assistant (NA)-B of sleepy during breat very difficult time from the fluids came directly onto the clothing property of the fluids came directly of the confirmed it was of the dot this technique. The directly of the chest rubby of the chest rubby or drink during meals, and used the chest rubby or drink during meals, and used the chest rubby or drink during meals, and used the chest rubby or drink during meals, and used the chest rubby or drink during meals, and used the chest rubby was not to be should not be giving was not opening. During interview of service designed (generally tired during sternal rubby while sleeping was experience, or was buring interview of director of nursing be awake prior to the DON confirment sternal rubby to stir would have stopped to the confirment of the polytoconfirment of the polytoc	on 8/17/16, at 9:00am. nursing onfirmed R2 was frequently alkfast, and stated she had a eeding R2. NA-B confirmed she R2 fluids while R2 slept, and rectly back out of her mouth protector. NA-B also confirmed to rub R2's chest to wake her without causing her pain to try t enough to push the fluids, and common practice in the facility to NA-B reported she had been a chest rub as an intervention to indicated she felt this was not a sist R2 to eat breakfast.  In 8/17/16, at 9:32 a.m. nursing reported R2 was usually tired confirmed she had in the past to on R2 to stimulate her to eat als. NA-A reported the chest used repeatedly, and staffing fluids or foods by mouth if	F 2	241			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		245597	B. WING _		08/18/2016
	PROVIDER OR SUPPLIER  IDE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE APPROPRIED	D BE COMPLÉTION
F 241 F 282 SS=D	and the manner R2 dignified dining exp all staff in the past I how to treat resider impairments.  The facility's Quality August 2009 indica cared for in a mannenhanced quality of individuality. Further shall treat cognitive dignity and sensitive 483.20(k)(3)(ii) SEF PERSONS/PER CATThe services provided by the staff of the th	It the dining table by the NA It was assisted was not a receivence. The DON confirmed that received education on that with dementia and cognitive  y of Life-Dignity policy, dated ted each resident would be there that promoted and for life, dignity, respect and ter, the policy indicated the staff the policy indicated the staff the life, with the policy indicated the staff the policy indicated the staff the life, with the policy indicated the staff the policy indicated the staff the life, with the policy indicated the staff the policy indicated the staff the life, with the policy indicated the staff the policy indicated the staff the life, with the policy indicated the staff the policy indicated the staff the life, with the policy indicated the staff the policy indic	F 24		9/26/16
	by: Based on observative review, the facility for directed by the indiversident (R28) who activities of daily live. Finding include: R28's care plan, reversely and impaired of problem and ADL so Alzheimer's disease.	tion, interview and document ailed to provide assistance as vidualized care plan for 1 of 3 required staff assistance for ing (ADLs).  vised on 7/21/16, identified cognition, had communication elf-care deficit related to e. The care plan listed various included for staff to ask		Corrective Action: Resident R28 f hair was removed on 8/18/2016. It plan was updated to include remo facial hair weekly with tub bath an Correction as it applies to other reall staff attended an education set 9/7/16 which included providing Al to all dependent residents per the care. Care plans for all current rewere reviewed and updated, if new regarding removal of facial hair or before 9/26/16.	Her care val of d prn. sidents: ssion on DL care ir plan of sidents eded

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245597	B. WING _		08/	18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	yes/no questions to and meet needs, and hygiene, dressing a During observation was noted to have facial hairs on her ther lip area and on her chin. The facial inch or longer.  On 8/16/16 at 9:19 white/black, coarse which extended over entire chin and und were approximately.  On 8/17/16, at 7:56 room eating breakfit to have white/black upper lip which extended over entire chin and hairs were approximately.  At 9:45 a.m. R28 wher room. R28 continues were approximately where and under her chin.  At 10:00 a.m. R28 wher in the dining room a station, playing ball R28 continued to he facial hair on her upher lip area, onto he chin area.	o determine needs, anticipate and to assist R28 with personal and oral care.  on 8/15/16 at 7:30 p.m. R28 many white/black, coarse upper lip which extended over to her entire chin and under hairs were approximately 1/4  a.m. R28 was noted to have facial hair on her upper lip er her lip area and onto her er her chin. The facial hairs of 1/4 inch or longer.  a.m., R28 was in the dining ast. R28 was again observed a.m., R28 was again observed a.m., coarse facial hair on her ended over her lip area, onto under her chin. The facial mately 1/4 inch or longer.  as seated in her wheelchair in tinued to have black/ white, nair on her upper lip which ip area, onto her entire chin	F 28	Reoccurrence will be prev or designee will audit the t completion of ADL care we monthly for compliance.  DON will report audit finding committee on a quarterly to direction.	imely eekly x 4 then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245597	B. WING _		08	/18/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 16561 US HIGHWAY 10 LAKE PARK, MN 56554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 282	dining room eating have black/ white, to upper lip which extender entire chin and facial hairs were appeared to 1:30 p.m. R28's remain the same.  On 8/18/16 at 9:25 routinely assisted FR28 required extender personal hygiene. Nousually gets shaved had time she would female residents. No coarse facial hair and her care plan to week.  On 8/18/16 at 10:38 (DON) confirmed From the composite the resident of the decision on where the provide the resident of the decision on where the provide the resident of the decision on where the provide the resident of the decision on where the provide the resident of the decision on where the provide the resident of the decision on where the provide the facility Plan, revised 8/200 be used in develop routines and will be	breakfast. R28 continued to thick, coarse facial hair on her ended over her lip area, onto under her chin area. R28 's proximately 1/4 inch or longer. facial hair was observed to  a.m. NA-D confirmed staff R28 with ADL 's and indicated sive assistance from staff for NA-D also indicated R28 d on her bath day and if she I go around and shave other IA-D verified R28 had a lot of nd indicated that it should be get shaved more than once a  B p.m. director of nursing R28's current care plan and ired assistance with grooming. expectation of staff would be ents with a razor and to in their bath days or when ated she felt staff could make ether facial hair needed to be distated "We need to look out	F 28	2			
F 312 SS=D	services to the residues 483.25(a)(3) ADL C	dents. CARE PROVIDED FOR	F 31	2		9/26/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245597	B. WING		08/18	3/2016
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 6561 US HIGHWAY 10 .AKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE (	(X5) COMPLETION DATE
F 312	daily living receives maintain good nutri and oral hygiene.	nable to carry out activities of the necessary services to tion, grooming, and personal	F 312			
	by: Based on observarinterview, the facility assistance for 1 of required assistance.  Findings include:  R28's annual Minima 7/18/16, indicated Fincluded: Alzheime heart failure. The Management of the severely cognitively extensive assistance personal hygiene, or R28's care plan, recalled the severely and activity self-care deficit relative to the severely relative to the severely cognitively extensive assistance personal hygiene, or R28's care plan, recalled the severely cognitively extensive assistance personal hygiene, or R28's care plan, recalled the severely cognitively extensive assistance personal hygiene, or R28's care plan, recalled the severely cognitively extensive assistance.  R28's annual Minima 7/18/16, indicated Findicated	tion, interview and document y failed to provide shaving 3 residents (R28) who with grooming.  The many displayments are sidents (R28) who with grooming.  The many displayments are sidents (R28) who with grooming.  The many displayments are sidents (R28) was a sidentified R28 was a sid		Corrective Action: Resident R28 fachair was removed on 8/18/2016. He plan was updated to include total as 1 to remove facial hair weekly with total and prn.  Correction as it applies to other residual staff attended an education sess 9/7/16 which included providing ADI (including the removal of facial hair) dependent residents per their plant care. Care plans for all current resiwere reviewed and updated, if need regarding ADL care on or before 9/2 Reoccurrence will be prevented by: or designee will audit the timely completion of ADL care weekly x 4 to monthly for compliance.  DON will report audit findings to the committee on a quarterly basis for fidirection.	er care ssist of tub idents: sion on L care to to all of dents led 26/16.  DON then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245597	B. WING		08	/18/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 16561 US HIGHWAY 10 LAKE PARK, MN 56554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 312	inch or longer.  On 8/16/16 at 9:19 white/black, coarse which extended ove entire chin and und were approximately  On 8/17/16, at 7:56 room eating breakf to have white/black upper lip which exte her entire chin and hairs were approxim  At 9:45 a.m. R28 w her room. R28 cont long, coarse facial I extended over her I and under her chin  At 10:00 a.m. R28 v in the dining room a station, playing ball R28 continued to he facial hair on her up her lip area, onto he chin area.  On 8/18/16, at 9:15 dining room eating have black/ white, t upper lip which exte her entire chin and facial hairs were ap	a.m. R28 was noted to have facial hair on her upper liper her lip area and onto her er her chin. The facial hairs / 1/4 inch or longer.  a.m., R28 was in the dining ast. R28 was again observed, coarse facial hair on her ended over her lip area, onto under her chin. The facial mately 1/4 inch or longer.  as seated in her wheelchair in inued to have black/ white, hair on her upper lip which ip area, onto her entire chin	F 31				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245597	B. WING		80	/18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	confirmed staff rour activities of daily liv R28 required extenpersonal hygiene. assist R28 with shado not always have indicated she felt R with her routine we. On 8/18/16 at 9:25 routinely assisted R28 required extenpersonal hygiene. Nusually gets shaved had time she would female residents. No coarse facial hair a on her care plan to week.  On 8/18/16 at 10:2 (RN)-B confirmed swith ADL's and R2 assistance from staindicated R28 was stated "the girls shand when needed." On 8/18/16 at 10:3 (DON) confirmed Rindicated R28 required R28 r	a.m. nursing assistant (NA)-C tinely assisted R28 with ing (ADL's) and indicated sive assistance from staff for NA-C indicated staff would aving when they had time but the time to shave R28. NA-C 28's face would be shaved	F 312			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245597	B. WING		08	/18/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 16561 US HIGHWAY 10 LAKE PARK, MN 56554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 312 F 431 SS=D	removed or not and for her best interest. Review of the facility Plan, revised 8/200 be used in development outines and will be who have responsitives to the residence to the residence to the residence to the residence of the facility must enable a licensed pharmactic of records of receipment of records of receipment of the facility must enable the records of receipment of the facility must enable the records of receipment of the facility must enable the records of receipment of the facility must enable the facility	I stated "We need to look out t."  ty policy titled, Using The Care 6 indicated the care plan shall ing the residents daily care available to staff personnel bility for providing care or dents.	F3	312		8/20/16	
	labeled in accordar professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartmen controls, and perminave access to the  The facility must propermanently affixed controlled drugs list	State and Federal laws, the all drugs and biologicals in the under proper temperature to only authorized personnel to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245597	B. WING _		08/	18/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 16561 US HIGHWAY 10 LAKE PARK, MN 56554			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	abuse, except whe package drug distributed quantity stored is readily detected	6 and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose can d.	F 43	1			
	by: Based on observareview, the facility accurate accounting 1 of 1 emergency. This deficient practany resident who refrom the E-kit.  Findings include: On 8/17/16 at 1:01 room tour was contained for a refrigerated as a refrigerated as a refrigerated E-kit in the clasp. The refrigerated E-kit in the taught and 10 vials medication, control to be stored in the Review of the facil Replacement Sign plastic strip on the contained lorazaper.	ation, interview and document failed to ensure a system for any of controlled medications in kit (E-Kit) utilized in the facility. It ice had the potential to affect might require the medication.  I p.m. the medication storage and acted with registered nurse plastic box was observed in the efrigerator, which facility staff igerated emergency stock -kit) for the facility. This had a red plastic strip attached ed plastic strip had the number be of the strip. RN-B opened the of lorazepam (anti-anxiety obled substance) were observed refrigerated E-kit.  Ity form titled E-Kit Lock to Out Sheet revealed the red refrigerated E-kit box, which em, had last been changed on the replacement red plastic strip lastic.		Corrective Action: The refewas reconciled as correct of The procedure was review supplying pharmacy and the pharmacist on 8/18/2016. To verify entry into the locked updated and explained to a the shift report and email to the shift report available in a limited numb sequence.  Correction as it applies one nurses will check the tags narcotic stock count.  Reoccurrence will be preveor designee will audit the eweekly x 4 then monthly for Consultant pharmacist will form monthly x 3 for composition on a quarterly be direction.	on 8/18/2016.  ed with the he consultant The procedure ed kit was all nurses via be all nurses. htry/tag hadded to the re now only er and in  going: Charge daily with  ented by: DON htry form r compliance. audit the entry liance.		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245597	B. WING		08/	18/2016
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 6561 US HIGHWAY 10 AKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	Continued From pa	ige 11 lacked documentation of any	F 431			
	additional change of refrigerated E-kit, a	of the red plastic strip for the and any ongoing monitoring of ck to prevent potential loss or				
	strip lock numbers been documented, strip/lock and confi RN-B then placed a	nad identified the red plastic were different than what had RN-B removed the red plastic rmed the contents of the E-kit. a new red plastic strip lock				
	the findings. RN-B documented time the changed was recorn the red plastic lock	I, and notified the pharmacy of confirmed the last he red plastic lock had been ded as 6/5/16. RN-B verified to secure the E-Kit, should ed as documented She				
	stated she was "no tag was changed." facility practice was check the red plast both refrigerated ar	t sure when the last time the RN-B indicated the usual for licensed staff to visually ic lock/security numbers on nd non refrigerated E-kits at				
	process of docume	ed the facility did not have a entation for such checks.				
	stated she'd spoke pharmacist who sta lorazepam in the E- recorded the new re	oximately 1:30 p.m. RN-B n with the facility's consultant ated she'd replaced the -Kit on 8/1/16 and had not ed red plastic strip lock				
	could the pharmaci red plastic strip she refrigerated E-Kit a	g removed the old one, nor st remember which numbered b'd removed from the at that time. RN-B also stated whether that was the only time				
	the E-Kit red plastic replaced since 6/5/	strip had been removed or 16, and indicated staff should d plastic strip routinely with				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245597	B. WING		08	/18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 431	(DON) confirmed the time the red plastic should have documed or replacement of a stated the pharmace today and stated, "stated the pharmace today and stated, also stated the pharmace. Which is also stated the pharmace is a stated the pharmace is	I a.m., the director of nursing the findings and verified each strip was removed, staff the ented the access and removal any medication. The DON also wist had been at the facility she was the one that did it and ag on the sheet." The DON remacist made an entry on the thank and stated staff should be astic strip routinely with	F4			

PRINTED: 09/12/2016 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245597 B. WING 08/16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 16561 US HIGHWAY 10 SUNNYSIDE CARE CENTER LAKE PARK, MN 56554 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

Facility ID: 00016

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,				E SURVEY IPLETED
	245597	B. WING			08	16/2016
ROVIDER OR SUPPLIER		2	1656	51 US HIGHWAY 10		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
ST. PAUL, MN 551  Or by email to: Marian.Whitney@s and Angela.Kappenman  THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the deficit  2. The actual, or pr  3. The name and/oresponsible for corprevent a reoccurre This facility was sure the Sunnyside Ca without a basement The original building is of Type II(00) coentrance and dayro constructed to the 1975 building and V (111) construction  The building has a sprinkler system. It is system that consist corridors and area	on-5145, or  tate.mn.us  m@state.mn.us  RRECTION FOR EACH or INCLUDE ALL OF THE DRMATION:  what has been, or will be, done iency.  roposed, completion date.  or title of the person rection and monitoring to ence of the deficiency.  reveyed as two building: re Center is a 1-story building or built at two different time. In gwas constructed in 1975 and not not additions were north and south sides of the were determined to be of Type on.  complete automatic fire The facility has a fire alarm its of smoke detection in the s open to the corridors that is		000			
	OF DEFICIENCIES F CORRECTION  ROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa ST. PAUL, MN 551  Or by email to: Marian.Whitney@s and Angela.Kappenman  THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the defic 2. The actual, or pr 3. The name and/oresponsible for corprevent a reoccurrent of the sunnyside Ca without a basement is of Type II(00) coentrance and dayro constructed to the 1975 building and V (111) construction  The building has a sprinkler system. It is system that consist corridors and area	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 passement built at two different time.	OF DEFICIENCIES FORRECTION  (X1) PROVIDER/SUPPLIER/LIA ABUILD  245597  ROVIDER OR SUPPLIER  DE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  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	ROVIDER OR SUPPLIER  DE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 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	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER SUPPLIER  245597  ROVIDER OR SUPPLIER  DE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES ((ACH) DEFICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 1 ST. PAUL, MN 55101-5145, or  Or by email to: Marian Whitney@state.mn.us  THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST in CLUDE 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 that is	OF DEFICIENCIES FORRECTION (X1) PROVIDERSUPPLIERCLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT CON A BUILDING 01 - MAIN BUILDING 01 (X2) PATE CON A BUILDING 01 - MAIN BUILDING 01 (X2) DAT CON A BUILDING 01 - MAIN BUILDING 01 (X2) DAT CON (X2) DAT CON (X2) DAT CON (X3) DAT CON (X3) DAT CON (X4) DA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC A. BUILDING <b>01 - MAIN BU</b>			(X3) DATE SURVEY COMPLETED	
		245597	B. WING		<u>-</u> -	08/	16/2016
	ROVIDER OR SUPPLIER  DE CARE CENTER			16	REET ADDRESS, CITY, STATE, ZIP CODE 561 US HIGHWAY 10 AKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa census of 28 at the	age 2 time of the survey.	K	000			
K 062 SS=D	NOT MET as evide NFPA 101 LIFE SA Required automatic continuously maint condition and are in periodically. 19.7.5 This STANDARD Based on observat facility has failed to the automatic sprir with NFPA 101 Life 19.7.6, and 4.6.12, Sprinkler Systems	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD c sprinkler systems are ained in reliable operating respected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: ations and staff inteview, the properly inspect and maintain akler system in accordance a Safety Code (00), Section NFPA 13 Installation of (99), This deficient practice that the fire sprinkler system is	K	062	Items in closet of room 113 were removed on 9/9/2016 ensuring there now 18" of space below the sprinkle deflector.  Staff were educated via Total Quality Management (TQM) communication	er ty	9/9/16
	functioning properl event of a fire and 28 residents and a and visitors. Findings include:	y and is fully operational in the could negatively affect 1 of the n udetermined amount of staff between 8:15 am to 12:00 pm			9/9/2016 regarding the requirement keep 18" of space below sprinkler deflectors.  Responsible Party: Maintenance Supervisor		
	on 08/16/2016 obs	servations and staff interview he closet of resident room 113 nan 18 inches below the					
K 075 SS=F	Administrator and	tice was verified by the Facility the Maintenance Supervisor. AFETY CODE STANDARD	К	075			9/9/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION 6 01 - MAIN BUILDING 01		PLETED		
		245597	B. WING		08/	16/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  16561 US HIGHWAY 10  LAKE PARK, MN 56554				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
K 075	exceed 32 gal (12 density of contained does not exceed capacity of 32 gal any 64 sq ft (5.9-s or trash collection greater than 32 gap rotected as a hazattended. 19.7.3 This STANDARD Based on observatacility has failed to carts in properly pwith the NFPA 10 edition (LSC) sect practice could affer and an undeterminif smoke or fire frow the corridors unter the co	sh collection receptacles do not 1 L) in capacity. The average er capacity in a room or space 5 gal/sq ft (20.4 L/sq m). A (121 L) is not exceeded within q m) area. Mobile soiled linen receptacles with capacities al (121 L) are located in a room exardous area when not 5.5 is not met as evidenced by: ations and staff interview, the o store large trash and linen rotected rooms in accordance I "The Life Safety Code" 2000 ion 19.7.5.5. This deficient ect the safety of all residents and amount of staff and visitors om one of these carts rendered	K 075	On 9/9/2016 one (1) bin of soiler was removed from each alcove remaining bin in each alcove doe exceed 32 gallons in capacity.  Staff were educated via Total Que Management (TQM) communica 9/9/2016 of the requirement and subsequent changes to the prace soiled linen storage.  Responsible Party: Maintenance Supervisor	The es not vality ation on tice of			

PRINTED: 09/12/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 0	2 - ADMINISTRATION ADDITION	COM	MPLETED
		245597	B. WING		08/	16/2016
	ROVIDER OR SUPPLIER		16	REET ADDRESS, CITY, STATE, ZIP CODE 561 US HIGHWAY 10 AKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	тѕ	K 000			
	Fire Safety					
	Building 02					
	Minnesota Departr Fire Marshal Divisi Sunnyside Care Co compliance with th in Medicare/Medica 483.70(a), Life Saf edition of National (NFPA) Standard 1	Survey was conducted by the nent of Public Safety, State on. At the time of this survey enter was found in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), ealth Care Facilities.				
	The Sunnyside Ca without a basemer The original buildir is of Type II(00) co entrance and dayrd constructed to the	reveyed as two building: re Center is a 1-story building at built at two different time. ag was constructed in 1975 and anstruction. In 2004 an additions were anorth and south sides of the agency were determined to be of Type an.				
	sprinkler system. I system that consist corridors and area	complete automatic fire The facility has a fire alarm ats of smoke detection in the s open to the corridors that is department notification.		EPOC		
		capacity of 34 beds and had a e time of the survey.				
	The requirement a	nt 42 CFR, Subpart 483.70(a) is I by:				

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.

09/09/2016

Electronically Signed

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION			IPLE CONSTRUCTION NG 02 - ADMINISTRATION ADDITION	COMPLETED			
		245597	B. WING		08	/16/2016		
	OVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE  16561 US HIGHWAY 10  LAKE PARK, MN 56554				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

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

PRINTED: 09/22/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	E SURVEY IPLETED	
		00016	B. WING		08/1	8/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SUNNYS	SIDE CARE CENTER		HIGHWAY 1 RK, MN 565				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficiner herein are not corrected shall I with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of tack of compliance. re-inspection with a result in the assess	nether a violation has been					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/09/16 **Electronically Signed** 

TITLE

STATE FORM 6899 If continuation sheet 1 of 15 PDZX11

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	MULTIPLE CONSTRUCTION UILDING:		(X3) DATE SURVEY COMPLETED	
		00016	B. WING		08/	18/2016	
	PROVIDER OR SUPPLIER	16561 US	DRESS, CITY, S' HIGHWAY 10 RK, MN 5655	)			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
2 000	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to electronic planter the State Incorrected prior to electronic planter the State Licensing federal software. To assigned to Minnes Nursing Homes.  The assigned tag in column entitled "ID statute/rule out of consummary Statement and replaces the "To correction order. The findings which are in after the statement, evidence by." Follow	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  Veyors of this Department's ove provider and the following re issued. Please indicate in of correction that you have ers, and identify the date when ted.  The ent of Health is documenting and numbers have been sota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the niolation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and	2 000				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.					

Minnesota Department of Health STATE FORM

TE FORM PDZX11 If continuation sheet 2 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
		00016	B. WING		08/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYSIDE CARE CENTER 16561 US HIGHWAY 10						
LAKE PARK, MN 56554  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE	
2 000	Continued From page 2		2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565			9/26/16
		omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility fa directed by the indiv	ent is not met as evidenced on, interview and document ailed to provide assistance as vidualized care plan for 1 of 3 required staff assistance for ng (ADLs).		Corrected		
	Finding include:					
	R28 had impaired of problem and ADL so Alzheimer's disease interventions which yes/no questions to	vised on 7/21/16, identified ognition, had communication elf-care deficit related to e. The care plan listed various included for staff to ask determine needs, anticipate and to assist R28 with personal nd oral care.				
	was noted to have r facial hairs on her u her lip area and ont	on 8/15/16 at 7:30 p.m. R28 many white/black, coarse apper lip which extended over to her entire chin and under hairs were approximately 1/4				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00016	B. WING		08/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	Continued From pa	nge 3	2 565			
	inch or longer.					
	On 8/16/16 at 9:19 white/black, coarse which extended ove entire chin and und were approximately On 8/17/16, at 7:56 room eating breakf to have white/black upper lip which extended the entire chin and hairs were approximately At 9:45 a.m. R28 wher room. R28 contons, coarse facial	is a.m., R28 was in the dining ast. R28 was again observed and are lip area, onto under her chin. The facial mately 1/4 inch or longer.  It is seated in her wheelchair in tinued to have black/ white, hair on her upper lip which lip area, onto her entire chin				
	in the dining room a station, playing ball R28 continued to he facial hair on her up	was seated in her wheelchair across from the nurse's with several other residents. ave black/ white, long, coarse oper lip which extended over er entire chin and under her				
	dining room eating have black/ white, t upper lip which exte her entire chin and facial hairs were ap	a.m., R28 was seated in the breakfast. R28 continued to chick, coarse facial hair on her ended over her lip area, onto under her chin area. R28 's oproximately 1/4 inch or longer. facial hair was observed to				
		a.m. NA-D confirmed staff R28 with ADL 's and indicated				

Minnesota Department of Health

STATE FORM PDZX11 If continuation sheet 4 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00016	B. WING		08/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	personal hygiene. Nusually gets shaved had time she would female residents. No coarse facial hair a on her care plan to week.  On 8/18/16 at 10:33 (DON) confirmed Rindicated R28 requipont DON indicated her to provide the resid remove their hair on needed. DON indicated her to provide the resid remove their hair on needed. DON indicated her to provide the resid remove their hair on needed. DON indicated her to provide the resid removed or not and for her best interest.  Review of the facility Plan, revised 8/200 be used in develop routines and will be who have responsil services to the residuality assessment could perform rand compliance.	Isive assistance from staff for NA-D also indicated R28 d on her bath day and if she d go around and shave other NA-D verified R28 had a lot of nd indicated that it should be get shaved more than once a 8 p.m. director of nursing R28's current care plan and ired assistance with grooming. expectation of staff would be lents with a razor and to n their bath days or when ated she felt staff could make either facial hair needed to be distated "We need to look out t."  Ty policy titled, Using The Care of indicated the care plan shall ing the residents daily care available to staff personnel bility for providing care or dent.  THOD FOR CORRECTION: Sing (DON) or designee could and procedures related to be denoted and procedures related to be a sauding to ensure of the sauding to ensure				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				

6899

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00016	B. WING		08/1	8/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SUNNYS	SUNNYSIDE CARE CENTER 16561 US LAKE PA						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
2 920	Subp. 6. Activities comprehensive reshome must ensure B. a resident who activities of daily liviservices to maintain and personal and of this MN Requirements.  This MN Requirements by: Based on observation interview, the facility assistance for 1 of required assistance.  Findings include:  R28's annual Minimal 7/18/16, indicated Fincluded: Alzheimentheart failure. The Miseverely cognitively extensive assistance personal hygiene, of R28's care plan, reversive assistance personal hygiene, of R28's care plan listed included for staff to determine needs, at to assist R28 with poral care.  During observation	is unable to carry out ing receives the necessary n good nutrition, grooming, ral hygiene.  ent is not met as evidenced on, interview and document y failed to provide shaving 3 residents (R28) who	2 920	Corrected		9/26/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		00016	B. WING		08/	18/2016
	PROVIDER OR SUPPLIER		DRESS, CITY, ST	,		
SUNNYSIDE CARE CENTER LAKE PA			RK, MN 5655	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 920	facial hairs on her ther lip area and on her chin. The facial inch or longer.  On 8/16/16 at 9:19 white/black, coarse which extended over entire chin and und were approximately.  On 8/17/16, at 7:56 room eating breakf to have white/black upper lip which extended over entire chin and hairs were approximately.  At 9:45 a.m. R28 wher room. R28 continued to her entire chin and under her chin.  At 10:00 a.m. R28 in the dining room a station, playing ball R28 continued to her acial hair on her up her lip area, onto her chin area.  On 8/18/16, at 9:15 dining room eating have black/ white, the upper lip which extended hairs were approximately.	a.m. R28 was noted to have facial hair on her upper lip area and onto her er her chin. The facial hairs / 1/4 inch or longer.  a.m., R28 was in the dining ast. R28 was again observed , coarse facial hair on her ended over her lip area, onto under her chin. The facial mately 1/4 inch or longer.	2 920			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00016	B. WING		08/	18/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
SUNNYS	SIDE CARE CENTER		HIGHWAY 10			
	T		RK, MN 5655			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 920	920 Continued From page 7		2 920			
	confirmed staff rout activities of daily living R28 required extensions assist R28 with shad on always have indicated she felt R with her routine week. On 8/18/16 at 9:25 routinely assisted R R28 required extensional hygiene. No usually gets shaved had time she would female residents. No coarse facial hair at	a.m. nursing assistant (NA)-C inely assisted R28 with ing (ADL's) and indicated sive assistance from staff for NA-C indicated staff would ving when they had time but the time to shave R28. NA-C 28's face would be shaved ekly bath.  a.m. NA-D confirmed staff 128 with ADL's and indicated sive assistance from staff for NA-D also indicated R28 d on her bath day and if she go around and shave other NA-D verified R28 had a lot of and indicated that it should be get shaved more than once a				
	(RN)-B confirmed s with ADL 's and R2 assistance from sta indicated R28 was stated "the girls shand when needed." dignified to have fact be taken care of. "  On 8/18/16 at 10:38 (DON) confirmed R indicated R28 requi DON indicated here to provide the resideremove their hair or needed. DON indicated R28 indicated R28 requi	5 a.m. registered nurse taff routinely assisted R28 to required extensive off for personal hygiene. RN-B to have her bath today and tould be shaving on bath days RN-B indicated it was not cial hair and stated " it should be shaving of nursing 28's current care plan and red assistance with grooming. Expectation of staff would be ents with a razor and to their bath days or when tated she felt staff could make either facial hair needed to be				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00016	B. WING	B. WING		8/2016
	PROVIDER OR SUPPLIER	16561 US	DRESS, CITY, S HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Review of the facilit Plan, revised 8/200 be used in developi routines and will be	I stated "We need to look out"  by policy titled, Using The Care 6 indicated the care plan shall ng the residents daily care available to staff personnel bility for providing care or	2 920			
	The director of nurs implement policies ensuring staff perfo according to reside assessment and as perform random au	THOD FOR CORRECTION: sing (DON) or designee could and procedures related to rm acitivites of daily living nt care plans. The quality surance committee could dits to ensure compliance.				
21610	and Preparation Are Subpart 1. Storage must store all drugs under proper tempe	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have	21610			8/20/16
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure a system for g of controlled medications in		Corrected		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00016	B. WING		08/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
SUNNYS	SUNNYSIDE CARE CENTER 16561 U					
	T		RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
21610	Continued From page 9		21610			
	1 of 1 emergency k	it (E-Kit) utilized in the facility.				
	Findings include:					
	room tour was cond (RN)-B. A green, planedication room residentified as a refrigmedication box (E-I refrigerated E-kit has to the clasp. The result of the control of the contained in the result of the contained lorazape (6/5/16, and indicated strip with number of the contained in the contained lorazape (6/5/16, and indicated strip with number of the contained in the contain	by form titled E-Kit Lock Out Sheet revealed the red refrigerated E-kit box, which m, had last been changed on red the replacement red plastic 004363 had been applied. Ilacked documentation of any of the red plastic strip for the nd any ongoing monitoring of reck to prevent potential loss or				
	strip lock numbers been documented, strip/lock and confir RN-B then placed a numbered 4198504 the findings. RN-B documented time the changed was record the red plastic lock.	and identified the red plastic were different than what had RN-B removed the red plastic remed the contents of the E-kit. In new red plastic strip lock and notified the pharmacy of confirmed the last the red plastic lock had been ded as 6/5/16. RN-B verified to secure the E-Kit, should and documented She				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00016	B. WING		08/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	SIDE CARE CENTER		HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	stated she was "not tag was changed." facility practice was check the red plastic both refrigerated an least daily, but state process of docume  On 8/18/16 at approstated she'd spoker pharmacist who stated she'd spoker pharmacist who state lorazepam in the Erecorded the new renumber after having could the pharmaci red plastic strip she refrigerated E-Kit ashe was not sure with the E-Kit red plastic replaced since 6/5/be checking the redication verificate.  On 8/18/16 at 10:4° (DON) confirmed the time the red plastic should have document or replacement of a stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated," sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated," sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated," sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated," sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated," sidd not record the talso stated the pharmace today and stated, "sidd not record the talso stated the pharmace today and stated," sidd not recor	t sure when the last time the RN-B indicated the usual for licensed staff to visually ic lock/security numbers on ad non refrigerated E-kits at ed the facility did not have a intation for such checks.  Eximately 1:30 p.m. RN-B in with the facility's consultant ated she'd replaced the e-kit on 8/1/16 and had not ed red plastic strip lock gremoved the old one, nor st remember which numbered et that time. RN-B also stated the hether that was the only time estrip had been removed or 16, and indicated staff should at plastic strip routinely with ion.  If a.m., the director of nursing the findings and verified each strip was removed, staff then the access and removal any medication. The DON also ist had been at the facility she was the one that did it and ag on the sheet." The DON remacist made an entry on the stand stated staff should be astic strip routinely with	21610			

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00016	B. WING	B. WING		8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
SUNNYS	SIDE CARE CENTER		HIGHWAY 16 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	.D BE	(X5) COMPLETE DATE
21610	SUGGESTED MET The director of nurs implement policies ensuring medication medications is mair assessment and as perform random au	THOD FOR CORRECTION: sing (DON) or designee could and procedures related to n reconcilliation of e-kit	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		21805			9/26/16
	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.			Corrected		

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Minneso	Minnesota Department of Health						
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00016	B. WING		08/18/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 565				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21805	Continued From pa	ge 12	21805				
	8:28 a.m. R2 was stable in the main disclosed with head do assistant (NA)-B sa attempted to awake observation. NA-B mouth, with the corand onto the clothir torso area. At 7:52 her closed fist and (sternum) several tirepeatedly called or and stated wake up scrunched up her factored. At 7:54 a.m. closed fist on R2's on name and stated to eyes, lift her head or continued to attem and oatmeal while I chair. While NA-B a beverage items into repeatedly spilled or onto the clothing principle.	on 8/17/16, from 7:32 a.m. to reated in a wheelchair at a ning room, R2's eye were own to her chest. Nursing at to the left of R2, and en R2 during the entire meal put a cup of fluids up to R2's atents running out of her mouthing protector around R2's upper a.m. NA-B proceeded to use rubbed R2's chest bone imes with her closed fist. NA-B at R2's first and last name, by wake up, wake up. R2 briefly ace, and her eyes remained a., NA-B repeated rubbing her chest bone, called out R2's awake up. R2 did not open her rattempt to make noise. NA-B pt to feed R2 apple juice, milk, R2 remained asleep in her attempted to pour the food and of R2's mouth, the contents out the sides of R2's mouth, otector.					
	was seated in a wh next to R2, and was service designee (S stated "I don't know comatose with your	eelchair at the same table s being assisted by the social SSD). At 8:03 a.m., NA-B what is worse" being mouth open with food in it or two sleepy heads over here, its					
	assistant (NA)-B co sleepy during break	8/17/16, at 9:00am. nursing onfirmed R2 was frequently stated she had a seding R2. NA-B confirmed she					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. BOILDING.			
		00016	B. WING		08/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	SIDE CARE CENTER		HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	attempted to give F the fluids came dire onto her clothing pr she used her fist to and stimulate her, y to get her coherent confirmed it was co do this technique. directed to use the stimulate R2. NA in dignified way to ass  During interview on assistant (NA)-A re during meals, and o used the chest rub or drink during mea rub was not to be u should not be giving R2 was not opening  During interview on service designee (S generally tired durin using sternal rubs a while sleeping was experience, or was  During interview on director of nursing of be awake prior to b The DON confirme sternal rubs to stim would have stopped that being done. T statements made a and the manner R2 dignified dining exp all staff in the past	R2 fluids while R2 slept, and ectly back out of her mouth rotector. NA-B also confirmed rub R2's chest to wake her without causing her pain to try enough to push the fluids, and ommon practice in the facility to NA-B reported she had been chest rub as an intervention to adicated she felt this was not a sist R2 to eat breakfast.  8/17/16, at 9:32 a.m. nursing ported R2 was usually tired confirmed she had in the past on R2 to stimulate her to eat als. NA-A reported the chest used repeatedly, and staff g fluids or foods by mouth if g her mouth.  8/17/16, at 9:56 a.m. social SSD) reported R2 was ang breakfast and confirmed and continuing to feed R2 not a dignified dining	21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00016	B. WING		08/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 5659			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	impairments.  The facility's Quality August 2009 indicated for in a mann enhanced quality of individuality. Further	of Life-Dignity policy, dated ted each resident would be er that promoted and life, dignity, respect and er, the policy indicated the staff ly impaired residents with	21805			
	The director of nurs implement policies dining expereience. assurance committe audits to ensure con	HOD FOR CORRECTION: ing (DON) or designee could and procedures dignified The quality assessment and ee could perform random impliance.  R CORRECTION: Twenty (21)				

6899