CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: PUED

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY THE				E STATE SURVEY AGENCY Facility ID: 00776		acility ID: 00776	
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245225 2.STATE VENDOR OR MEDICAID NO. (L2) 685740000 (L5) SLEEPY EYE, M. 5. EFFECTIVE DATE CHANGE OF OWNERSHIP. 7. PROVIDER/SURPLE		E CARE CENTE ENUE SOUTHW	R	(I	L6) 56085	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUF	PPLIER CATEGOR' 05 HHA	Y 09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 06/16 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	// 2016 (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 HOSPIC	E	FISCAL YEAR ENDING 06/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	65 (L18) 65 (L17)	X B. Not in Com	nce With quirements			proved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code B*	Following Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room (L12)	ces Limit tor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 65	19 SNF	ICF	IID		15. FACILIT 1861 (e) (1	Y MEETS) or 1861 (j) (1):	(L15)	
(L37) (L38) (L39) (L42) (L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):								
17. SURVEYOR SIGNATURE Date : Cynthia Wentkiewicz, HFE NE II 07/11/2016 (L19)				(L19)		ohnsTon, Pr	proval ogram Specialis	Date: (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE O	R SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C	IVIL			ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	1513)
22. ORIGINAL DATE OF PARTICIPATION 12/01/1978 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)		VOLUNTAR 01-Merger, C		INVOLUNT 05-Fail to Mo	ARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)			voluntary Termination son for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARI	KS		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	ГЕ	Posted 07	7/29/2016 Co.		
	(L32)			(L33)	DETERM	INATION APPRO	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 30, 2016

Mr. Steve Fritzke, Administrator Sleepy Eye Care Center 1105 Third Avenue Southwest Sleepy Eye, Minnesota 56085

RE: Project Number S5225026

Dear Mr. Fritzke:

On June 16, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793

Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 26, 2016, the Department of Health will impose the following remedy:

State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of

compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 16, 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 December 16, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 07/28/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245225	B. WING		<u> </u>	06	/16/2016
	ROVIDER OR SUPPLIER EYE CARE CENTER		•	11	REET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST LEEPY EYE, MN 56085		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F (000			
F 241 SS=D	as your allegation of Department's accept enrolled in ePOC, yo at the bottom of the f form. Your electronic be used as verification. Upon receipt of an accon-site revisit of your validate that substan regulations has been your verification. 483.15(a) DIGNITY AINDIVIDUALITY The facility must promanner and in an en	ance. Because you are ur signature is not required irst page of the CMS-2567 submission of the POC will on of compliance. Acceptable electronic POC, an facility may be conducted to tial compliance with the attained in accordance with AND RESPECT OF	F:	241			7/26/16
	by: Based on observation review, the facility fail for 1 of 1 resident (Rover two days and exand anger due to corregarding her need for staff failure to follow Findings include: Review of the minimum 5/7/16, revealed R35	on, interview, and document led to provide dignified care (35) who remained in bed for experienced feelings of guilt naments made by staff or specialized equipment and up on her concerns.			It is the practice of the Sleepy Eye Car Center to promote care for residents in manner and in an environment that promotes maintenance or enhancement of each resident is quality of life. Resident #35 Social Services will provide support to resident twice a week for emotional webeing as resident refuses to see in house psychologist. All staff will be educated on resident	a it	
		CURRULER REPRESENTATIVE'S SIGNATUR	_ '		TITLE		(Y6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

07/08/2016

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 F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245225	B. WING			06/	/16/2016
	ROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 105 3RD AVENUE SOUTHWEST LEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 241	to rejection of care ar assistance of at least (moving between sur wheelchair, standing bath/toilet). On 6/14/16, at 10:25 lying down in bed dur surveyor. On 6/15/16 observed lying in her during random obser 6/14/16, and 6/15/16 providing assistance R35 replied "I plead to a previous survey, fathe facility got "dinger and so she was hesit explained the nursing April and told her the and the facility would new sling. Approximate facility received the nreported it was heavy assistants (NA) tried it was very uncomfort wheelchair. R35 expl health concerns which other slings in the facility health concerns which at almost tipped. The something was observed she felt something wrong that spend so much mone reported she told state refund on the sling are know and had to get	a.m. R35 was observed ring an interview with at 4:01 p.m. R37 was bed, as she had been vation during survey on R35 was asked if staff were to her transfer out of bed. he 5th". R35 explained, after cility staff had told residents d" due to resident complaints	F	241	rights, focusing on the right to dignity be July 26th, 2016. Relias Learning training was set up to educate all staff on resident rights. The Director of Nursing is responsible overall compliance. The facility alleges that will be in substantial compliance and complete a action items by July 26th, 2016.	for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		245225	B. WING _			06/16/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	<u> </u>	10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 241	family member who were ported the nursing saw she was emotion reported no nurse, phococupational therapis sling and lift use for had worked with her reported she felt angiget out of bed and resling. At 1:58 p.m. Ramember and a busing her the cost of the ned devices used to assis residents. For some rused to hold resident. On 06/16/2016, at 8:3 nurse working on Rameter and a busing the working on Ramember and a busing her the cost of the ned devices used to assis residents. For some rused to hold resident. On 06/16/2016, at 8:3 nurse working on Rameter and getting "it's a commotion" and went with certain slind any of them." LPN-A purchased one for her complained that it was Ra5's wheelchair. LP the director of nursing concern and instead initiate the conversation was alert and oriente Ra55 "my hands are till LPN-A reported she to expensive, but did not	lay to spend time with a visited earlier in the day. R35 assistants had come in and hal in the last few days. R35 hysical therapist or at had come in to assess her. Only nursing assistants and the new sling. R35 hy no one was helping her solve problems with the resolve problems	F 2	1			
	R35 but did not docu and LPN-A reported l for two days. At 10:0	the new sling and lift with ment this assessment. DON R35 had not been out of bed 1 a.m. DON reported it would staff to discuss cost of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245225	B. WING _		06/	/16/2016
	ROVIDER OR SUPPLIER EYE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI		SHOULD BE	(X5) COMPLETION DATE		
F 241 F 242 SS=D	9:26 p.m. until after s 6/16/16, at 10:01 a.m. Review of progress n revealed the following not like either slings v she refused to use to that works with lift and 5-10 mins and insistir sling is uncomfortable have to talk to DON or Review of the progres 6/16/16, revealed no related to R35's concibarriers to getting out intervention on 6/16/16 Review of R35's care interventions related ther sling until 6/16/16 483.15(b) SELF-DET MAKE CHOICES	f care for transferring transfer from 6/13/16, at urveyor intervention on otes, dated 6/12/16, g "Resident upset as does we have for her, the new one day and tried the other sling d only sat up in chair for ng to be put back to bed as e, reported that resident will on Monday about slings." as notes for 6/1/16, through assessment or intervention erns with use of new sling or to f bed until surveyor 16, at 10:16 a.m.	F 2			7/26/16
	schedules, and health her interests, assessinteract with members inside and outside the about aspects of his of are significant to the i	n care consistent with his or ments, and plans of care; s of the community both e facility; and make choices or her life in the facility that				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245225	B. WING		00	6/16/2016	
NAME OF P	ROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1	<i>,,</i> 10,2010	
				1105 3RD AVENUE SOUTHWEST			
SLEEPY E	YE CARE CENTER			SLEEPY EYE, MN 56085			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 242	Continued From page	e 4	F 24	42			
	Based on interview a facility failed to asses preferences for 1 of 1 choices (R7).	and document review, the		It is the practice of the Sleepy E Center to ensure residents have to make choices about aspects her life in the facility that are sig the resident.	e the right of his or		
	revealed R7 had seve had no behaviors related required physical help transfer only for bathin R7's family member, phone on 6/14/16, at used to shower at leathome. F-A reported so frequently R7 was bated 15/16, at 2:29 p.m. with R7 in his room. Fasked her about how bathe each week and R7 or another family was getting bathed at while at home and we bathe R7 at least twice trouble remembering	ng. (F)-A was interviewed via 3:24 p.m. F-A reported R7 st three times a week at		Policy and nursing assessments reviewed. Admission nursing as was revised to include the resid preference of type of bath, time and frequency of bath with family resident on admission. Bathing preferences will be reviewed questionary care conferences or as needed adjustments will be made to the to accommodate the resident expreferences. Resident #7 Resident was interviewed regard preference on the type of bath, bath, and frequency of bath. Catwas reviewed and updated. All current residents will be reviet the care conference schedule a plans will be updated as needed.	seessment ent s of bath, ly and earterly at and care plan ding time of ire plan ewed on nd care		
	(DON) reported the b determined by room is scheduled once a we request if they wanted once each week. R7 each week. At 3:08 p no system to assess of bathing times resid	.m. the director of nursing athing schedule was number and residents were ek. A resident would need to d to be bathed more than was getting bathed once .m. DON reported there was and document the number lents wanted each week. entation about the bathing		Nursing staff will be educated or admission assessment and new of including the resident is prefetype of bath, time of bath, and from the property of bath with family and resident admission and reviewed quarter conferences by July 26th, 2016. The Director of Nursing is response overall compliance.	v practice erence of requency on rly at care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245225	B. WING		06/16/2016
	ROVIDER OR SUPPLIER YE CARE CENTER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 246 SS=D	preferences of R7. On 6/15/16, at 3:16 pt (LSW)-A reported the system related to assign preferences. Review of the bath air revealed R7 was schibathing once each with care bathing informative revealed R7 was batt 6/5 and 6/12. 483.15(e)(1) REASO OF NEEDS/PREFER A resident has the rig services in the facility accommodations of i	o.m. the social worker, ere was no documentation or sessing resident bathing dide schedule, undated, eduled to be assisted with eek. Review of the point of tion from 5/1/16, to 6/15/16, thed on 5/1, 5/10, 5/15, 5/29, NABLE ACCOMMODATION RENCES of the to reside and receive with reasonable individual needs and when the health or safety of	F 24	The facility alleges that will be in substantial compliance and complete action items by July 26th, 2016.	all 7/26/16
	by: Based on observation review, facility failed reach for 1 of 1 reside for meeting cares. On 6/15/16, at 8:43 a interview, call light was reach if she needed a located hanging from floor next to R97's be	on, interview and document to ensure call light was within ent (R97) dependent on staff a.m. during resident as not observed within R97's assistance from staff. It was a wall call light box onto the ed. Registered nurse (RN)-A e hall and came into R97's		It is the practice of the Sleepy Eye C Center to ensure a resident has the ri to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. All staff will be educated on important residents having call light within reactions.	ght ons ne

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245225	B. WING _			06/16/2016	
	ROVIDER OR SUPPLIER EYE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 246 F 280 SS=D	door. RN-A verified of draped call light cord R97, and clipped it to R97 if she could push pushed red button. We the call light, RN-A st times and does need it." R97's face sheet inclunspecified sequelate generalized muscle we R97's care plan dated living interventions in with wheelchair, physwalker, and monitor for G0 6/15/16, at 3:27 p (DON) stated her explosed in place for resident reach floor or bedside stand 483.20(d)(3), 483.10 PARTICIPATE PLAN. The resident has the incompetent or other incapacitated under the participate in planning changes in care and	ad in wheelchair next to room all light was not within reach, over bed, brought it over to the sweater. RN-A asked in red call light and R97 //hen asked if R97 could use ated she "uses button at it to be there for her to use uded diagnoses of of cerebral infarction and weakness. If 6/6/16, activities of daily cluded physical assist of one sical assist of one with or assist with transfers. I.m. director of nursing bectation was that call light ent to reach it. Is call light use policy dated at all times, never on the di." I(k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be he laws of the State, to g care and treatment or treatment. It is plan must be developed	F 2	on resident s rights by July 2 A random audit will be perform by the Interdisciplinary Team to call lights are within reach of a The Director of Nursing is responserall compliance along with communicating results of audit meeting. The facility alleges that it will be substantial compliance by July	ned weekly to ensure all residents. ponsible for its to QA	7/26/16	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245225	B. WING		06/16/2016	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	33.10.23.13	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 280	interdisciplinary team physician, a registere for the resident, and odisciplines as determ and, to the extent prathe resident, the resident, the resident representative; and revised by a team each assessment.	es 7 essment; prepared by an and that includes the attending downward nurse with responsibility bether appropriate staff in sined by the resident's needs, acticable, the participation of elent's family or the resident's f	F 28			
	review, the facility fail for 1 of 3 resident (R6 conditions and 1 of 1 a change in transfer ther concern and discretion for the concern and assistance of at least (moving between surface) bath/toilet). On 6/14/16, at 10:25 lying down in bed dur surveyor. On 6/15/16 observed lying in her	residents (R35) reviewed for equipment, which caused omfort. set (MDS), dated 5/7/16, gnitively intact, had no ations, behaviors related to required extensive two staff for transfers face to or from: bed, chair, position, excluding to/from		It is the practice of the Sleepy Eye Ca Center to develop a comprehensive ca plan within 7 days after the completion the comprehensive assessment, prepa by an interdisciplinary team as determi by the resident s needs, and the participation of the resident and family and to periodically review and revise th care plan after each assessment. Resident #35 Care plan has been reviewed and revis to include type of skin alteration and interventions for skin alteration. Open area on coccyx is healed. Resident #66 Care plan has been reviewed and revis to include type of skin alteration and interventions for skin alteration and interventions for skin alteration. Staff will be educated by July 26th, 20- to ensure plan of care reflects current standards.	of of ored ned , nee sed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG	l\ /	(X3) DATE SURVEY COMPLETED	
		245225	B. WING _			06/16/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	providing assistance R35 explained the nuin April and told her to and R35 would need one week ago, the fator her to use. R35 rewhen the nursing assistant her on Sunday it would not fit in her wishe had physical head difficult to use other a reported when she the situation she started to well up at this time physical therapist or come in to assess slinursing assistants hanew sling. R35 report was helping her get of problems with the slind devices used to assist residents. For some used to hold resident On 06/16/2016, at 8: nurse working on R3 about R35 not getting "it's a commotion" and went with certain slind any of them." LPN-A director of nursing (Dand instead believed the conversation with and oriented. During DON reported she hanew sling and lift with this assessment. DO	R35 was asked if staff were to her transfer out of bed. Ursing staff had spoken to her the slings were not a right fit a new sling. Approximately scility received the new sling eported it was heavy and sistants (NA) tried to use it a was very uncomfortable and theelchair. R35 explained that alth concerns which made it slings in the facility. R35 thought about the whole to well up, and was observed at R35 reported no nurse, occupational therapist had any and lift use for her. Only and worked with her and the ted she felt angry no one but of bed and resolve ng. (Mechanical lifts are	F 2	A random audit will be performed interdisciplinary Team week residents to ensure specific alterations and interventions in the plan of care. The Director of Nursing is recompliance along with commendates of audits to QA meets. The facility alleges that it wis substantial compliance and action items by July 26th, 2	ormed by the kly on 10% of skin s are included esponsible for municating ting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245225	B. WING		06/16/2016		
	ROVIDER OR SUPPLIER EYE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	, 00.70.20.0		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	O BE COMPLETION		
F 280	R35 had trouble ad sling and was spenresponded she would and did not know. On 6/16/16, at 9:56 assisted R35 out of NA-B reported R35 reported it did not fit too thick. NA-B reported she and sling R35 prefer almost tipped. NA-B on Monday, 6/13/16 the new sling. Review of the point revealed R35 did not 9:26 p.m. until after 6/16/16, at 10:01 a. Review of progress revealed the following she refused to use that works with lift at 5-10 mins and insis sling is uncomfortat have to talk to DON Review of the progress following the progress of	an had been updated since justing to the use of the new ding more time in bed. DON ald have to check the care plan a.m. NA-B reported she had bed on Saturday and Sunday. was upset with the sling and tin the wheelchair and was ported transferring from bed to the for R35 and R35 was upset. The had attempted to use the lift erred to transfer her and it as reported she told the DON and transfer from 6/13/16, at surveyor intervention on m. Inotes, dated 6/12/16, ng. "Resident upset as does as we have for her, the new one today and tried the other sling and only sat up in chair for ting to be put back to bed as one. reported that resident will all on Monday about slings." The sess notes for 6/1/16, through to assessment or intervention on the corns with use of new sling or ut of bed until surveyor 5/16, at 10:16 a.m.	F 280				

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245225	B. WING			0	6/16/2016
	ROVIDER OR SUPPLIER YE CARE CENTER			1105 3F	TADDRESS, CITY, STATE, ZIP CODE RD AVENUE SOUTHWEST PY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	was modified and re refusing new sling, see Continue to work with was also revised on "Transfers-requires periodical (specialized) hoyer like were assigned to nure no guidance on how "work with resident". revised on 6/16/16, to get up daily and reprefers to stay in beguidance on handlin bed or to review risk. There were no interved to spite concerns relapproach to use or recomfortable. There witigate the potential bed because of concistin, comfort, mobilities uses.	6. On 6/16/16, the care plan ad "Resident has been tating it is uncomfortable. h resident." The care plan	F	280			
	forearm and indicate area on the left outer Care Plan with revising "Focus: Resident has outer heel. Has the fincontinent of urine, appetite variesupd pressure ulcer on left will remain intact. Introduced assistance with report while sitting and requand repositioning events. (resident) does	ed that R66 had pressure r heel. ion date 3/24/16, read, s a pressure area on left					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245225	B. WING		06/16/2016	
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	1 00.10.20.10	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 280	and Nursing Assistathe Nurse. Keep resfree. Alternating air reducing device for assessment by Lice care plan lacked curforearm. R66's admission redincluded Alzheimer's Delusional, Hallucinagitation. Progress note dated "IDT (interdisciplinathiscuss pressure arheel. Areas are hearinterventions." Progress note dated indicated, "Skin tearforearm. 1.5 cm x 1 strips to close and reparties and filed va. Nurses Weekly Word 6/15/16, at 1:55 p.m. 1.2 x 0.6 100% (per Continue to monitor.) On 6/15/16, at 3:45 stated, weekly wour weekly and R66 skin 6/15/16 was 1.2 cm. On 6/16/16, at 9:32 care plan lacked curent R66 has a pressure stated, her expectations.	ident's bed linen dry & wrinkle mattress for bed. Pressure chair. Weekly skin nsed Nurses." However the rrent skin tear on right cord with diagnosis which is disease, Dementia, ations, restlessness and d 6/1/16, at 2:16 p.m. read, ry team) team () met to leas on right great toe and left led. Continue current d 6/13/16 at 10:39 p.m. of unknown cause to right cm (centimeter) used steri lotified all incident report (Vulnerable adult)." und Documentation dated in read, "Right arm skin tear cent) granulation intact. until healed." p.m. registered nurse (RN)-A and assessments are done in tear measurement on	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245225	B. WING			06/	16/2016
	ROVIDER OR SUPPLIER YE CARE CENTER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 105 3RD AVENUE SOUTHWEST LEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 SS=D	In addition, RN-A mer on her left outer heel Policy and procedure AND PROCEDURE, indicated, "9. The car updated as the care of the resident changes will be added to compresolution in 30 days) times. It is recommen printed annually." 483.25 PROVIDE CA HIGHEST WELL BEIL Each resident must reprovide the necessary or maintain the higher mental, and psychosol	oncerns such as skin tears. Intioned, R66's pressure area healed. Ititled CARE PLAN POLICY dated revised 3/2012, and e plan is to be changed and changes for the resident as (Any temporary problems brehensive care plan if no . It is to be current at all ded that the care plan is RE/SERVICES FOR NG eceive and the facility must by care and services to attain st practicable physical,		309			7/26/16
	by: Based on observation review, the facility fail reviewed with a recer equipment (R35) was care and services to a physical, social and p preferences to spend Findings include: Review of the minimum	provided with appropriate successfully meet her sychosocial needs and			It is the practice of the Sleepy Eye Car Center to ensure each resident receive the necessary care and services to atta or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan ocare. Resident #35 Reviewed resident s care plan and updated transfer lift assessment. A	es ain	

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	, 00.10.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 309	to rejection of care a assistance of at leas (moving between su wheelchair, standing bath/toilet). On 6/14/16, at 10:25 lying down in bed do surveyor. On 6/15/10 observed lying in he during random obse 6/14/16, and 6/15/16 providing assistance R35 replied "I plead a previous survey, fathe facility got "dingerand so she was hes explained the nursin April and told her the and the facility would new sling. Approxim facility received the reported it was heave assistants (NA) tried it was very uncomfor wheelchair. R35 explained the reported it was heave assistants in the facility other slings in the fathought about the wind well up, and was ober R35 reported she fe	ucinations, behaviors related and required extensive at two staff for transfers race to or from: bed, chair, g position, excluding to/from 5 a.m. R35 was observed uring an interview with 6, at 4:01 p.m. R37 was r bed, as she had been rvation during survey on 7 B. R35 was asked if staff were to ther transfer out of bed. the 5th". R35 explained, after acility staff had told residents and to complain. R35 g staff had spoken to her in a slings were not a right fit do need to spend \$700 on a lately one week ago, the new sling for her to use. R35 by and when the nursing to use it with her on Sunday rtable and would not fit in her plained that she had physical ch made it difficult to use cility. R35 reported when she hole situation she started to served to well up at this time. It guilty and like she had done	F 309	<u> </u>	viewed of the 0% of ects July for ole for ing
	something wrong the spend so much mon reported she told sta refund on the sling a know and had to get sling because it was	at required the facility to see on a sling for her. R35 aff she hoped they got a sind they told her they did not a corporate approval for the \$700. R35 reported she was day prior as scheduled. R35			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245225	B. WING _			06/16/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	•	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		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 309	spend time with a fan earlier in the day. R3 assistants had come emotional in the last nurse, physical thera had come in to assess Only nursing assistant the new sling. R35 rewas helping her get of problems with the slind devices used to assist residents. For some nused to hold resident On 6/15/16, at 4:15 preported they had just shift. They reported F special events. NA-CR35 assistance out of shift on 6/14/16, becaused to hold resident on 6/14/16, at 8:25 at approximately two ceause working on R3 about R35 not getting "it's a commotion" and went with certain slind any of them." LPN-A purchased one for he complained that it was her wheelchair. LPN-the director of nursing concern and instead initiate the conversation.	get out of bed today to nily member who visited 5 reported the nursing in and saw she was few days. R35 reported no pist or occupational therapist is sling and lift use for her. In the had worked with her and ported she felt angry no one out of bed and resolve ing. (Mechanical lifts are set staff in transferring mechanical lifts, a sling is so during the transfer.) I.M. NA-C and NA-D it arrived for the evening R35 only got of of bed for reported she did not offer if bed during the evening in suse R35 was "emotional". I.M. surveyor observed an intimeters long slit on R35's intimeters long slit on R	F3	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245225	B. WING		06/16/2016	
	ROVIDER OR SUPPLIER EYE CARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	, 337333	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 309	LPN-A reported she expensive, but did n the same interview, assessed the use of R35 but did not door reported the open and discovered the day pure LPN-A reported R35 two days. DON and lying in bed all day in the open area on the the care plan had be trouble adjusting to twas spending more she would have to conot know. At 10:01 a inappropriate for stawith R35. On 6/16/16, at 9:56 assisted R35 out of NA-B reported R35 reported it did not fit too thick. NA-B reported she to 6/13/16, that R35 had On 6/16/16, at 10:01 assisted R35 to tran R35 readily agreed that transfer. All three starecliner. R35 reported on the sling in the reup. DON tucked the seats of the chair. R	tied, this is what I have." told R35 the sling was ot tell R35 the cost. During the DON reported she had the new sling and lift with ument this assessment. DON rea on R35's coccyx was orior, on 6/15/16. DON and is had not been out of bed for LPN-A did not believe R35's impacted the development of the coccyx. DON was asked if the use of the new sling and time in bed. DON responded theck the care plan and did them. DON reported it would be fif to discuss cost of the sling a.m. NA-B reported she had bed on Saturday and Sunday. was upset with the sling and in the wheelchair and was rted transferring from bed to for R35 and R35 was upset. old the DON on Monday, and trouble with the new sling. I a.m. NA-A, NA-B and DON sfer from her bed to recliner. To have DON assess the aff helped position R35 in her ad it was uncomfortable to sit coliner because it was puffing sling between the arms and	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	l` '	(X3) DATE SURVEY COMPLETED	
		245225	B. WING _			06/16/2016
	ROVIDER OR SUPPLIER EYE CARE CENTER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	tickling her hair. R35 it was just because sadjusted to the new still sitting in her reclia a little hot and awkwapassing trays at the tronditioner. At 1:58 puncomfortable becausling. R35 was still sittle Review of R35's curr prescriber order, date hours every day and no orders directing Review of the point of June 16th revealed Feach day, until 6/10/assistance between 5/16/16 through 5/22 day on 5/23/16 throut times per day on 5/30-6 times per day on transfers on 6/10/16) between 6/13/16 and 6/13/16 at 9:26 p.m. intervention on 6/16/Review of R35's care interventions related her sling until 6/16/16 On 6/16/16, the care "Resident has been ris uncomfortable. Co The care plan was all	vard and the nursing ted the sling earlier as it was reported she did not know if she would have to get sling. At 12:01 a.m. R35 was iner and felt the sling was still ard. The dietary manager, time, turned on the room air o.m. R35 said she was still use there were boards in the sitting up in her recliner. Tent orders revealed a eed 2/3/16, "Up daily for 2-3 evening shift." There were tas to remain in bed. Of care from May 16th until R35 transferred at least once 16. R35 transferred with staff 1-3 times each day on 12/16; between 2-4 times each gh 5/29/16; between 2-6 0/16 through 6/5/16; between 6/6/16 through 6/5/16; between 6/6/16 (no transfers from until after surveyor 16 at 10:01 a.m.)	F3	309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	l\ /	(X3) DATE SURVEY COMPLETED	
		245225	B. WING _			06/16/2016
	ROVIDER OR SUPPLIER EYE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	· •	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	was no guidance on to "work with residen revised on 6/16/16, to get up daily and reprefers to stay in bed guidance on handling bed or to review risk. There were no intervidespite concerns relapproach to use or not comfortable. There witigate the potential bed because of concistin, comfort, mobilities uses. Review of progress revealed the following not like either slings she refused to use to that works with lift ar 5-10 mins and insisting is uncomfortable have to talk to DON Review of the progres 6/16/16, revealed no related to R35's concibarriers to getting out intervention on 6/16/16. Progress note, dated "coccyx-Pressure: Le Depth=0, Stage II Opskin assessment, da concerns. A progress scanned and emailed the survey. The note	to nursing assistants. There how nursing assistants were tt". The care plan was also onote "Encourage resident eposition/offload. Resident derection and benefits of this refusal. There was noted to sling, such as nethods to make her more were no interventions to dimpact of not getting out of the series related to sling, such as expected to sli	F3	309		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l l	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245225	B. WING			06/16/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pag time. Area determine incontinence, not pre	ed to be caused by	F 3	09			

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PRINTED: 07/11/2016 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - SLEEPY EYE CARE CENTER B WING 245225 06/14/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1105 3RD AVENUE SOUTHWEST **SLEEPY EYE CARE CENTER** SLEEPY EYE, MN 56085 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ΙĐ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE 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. Sleepy Eye 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/08/2016

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: 00776

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	ING 01 - SLEEPY EYE CARE CENTER		COMPLETED	
		245225	B. WING		06	/14/2016
	PROVIDER OR SUPPLIER EYE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085		
(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	Angela.Kappenma <mailto:angela.ka 1.="" 1985,="" 2.="" a="" actual,="" addition="" be="" building="" by="" care="" co="" constoriginal="" corprevent="" correct="" defice="" deficiency="" description="" determin<="" determined="" eye="" facility="" following="" for="" formal="" has="" info="" mus="" obuilding="" of="" or="" plan="" possible="" reoccurr="" sleepy="" sufficiently="" surfaced="" td="" the="" to="" was=""><td>state.mn.us hitney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> PRRECTION FOR EACH ST 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. Center is a 1-story building. The ructed at 2 different times. The as constructed in 1972 and was of Type II(000) construction. In a constructed and was of Type II(000) construction. all building and the 1 addition pe of construction and meet the allowed for existing buildings, veyed as one building. ire alarm system with smoke rridors and spaces open to the monitored for automatic fire ation. capacity of 54 beds and had a</td><td></td><td></td><td></td><td>×</td></mailto:angela.ka>	state.mn.us hitney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> PRRECTION FOR EACH ST 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. Center is a 1-story building. The ructed at 2 different times. The as constructed in 1972 and was of Type II(000) construction. In a constructed and was of Type II(000) construction. all building and the 1 addition pe of construction and meet the allowed for existing buildings, veyed as one building. ire alarm system with smoke rridors and spaces open to the monitored for automatic fire ation. capacity of 54 beds and had a				×

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 11 - SLEEPY EYE CARE CENTER	(X3) DATE SURVEY COMPLETED	
		245225	B. WING			06/	14/2016
NAME OF PROVIDER OR SUPPLIER SLEEPY EYE CARE CENTER			11	REET ADDRESS, CITY, STATE, ZIP CODE 05 3RD AVENUE SOUTHWEST LEEPY EYE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Continued From pa	enced by:	ΚC				
	NFPA 101 LIFE SA	FETY CODE STANDARD	K)25			6/21/16
SS=E	least a one half hor constructed in accordance barriers shall be per atrium wall. Windows fire-rated glazing of steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD is STANDARD is STANDARD is smoke barriers shall be per atrium wall. Windows	is not met as evidenced by: nall be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an ws shall be protected by r by wired glass panels and			The Environmental Service Dire inspected the inner and outer wa the lay in ceiling in all hallways, i Hall #1 and Hall #3 as identified survey deficiency report. All penthat were not in compliance were with fire-rated caulk.	alls above ncluding in the etrations	
	FINDINGS INCLUI	DE:					
	between the hours observation reveal	pection on June 14, 2016, of 10:30 AM and 1:30 PM, ed penetrations above the d wires at the Hall #1 and Hall vall.					
K 054	Maintenance Supe	tice was verfied by the rvisor. AFETY CODE STANDARD	K	054			6/30/16
SS=E	activating door hole maintained, inspec with the manufactu	e detectors, including those d-open devices, are approved, sted and tested in accordance arer's specifications. 9.6.1.3 is not met as evidenced by:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - SLEEPY EYE CARE CENTER	I) COM	(X3) DATE SURVEY COMPLETED	
		245225	B. WING		06/	14/2016	
	PROVIDER OR SUPPLIER EYE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 054	activating door hold maintained, inspect with the manufacture. FINDINGS INCLUIT On 6/14/2016 betwee during a review of facility staff, it was detector sensitivity since 06-10-2013.	de detectors, including those deopen devices, are approved, ted and tested in accordance arer's specifications. 9.6.1.3 DE: Veen 10:30 AM and 1:30 PM, available records provided by revealed that the smoke test had not been conducted	KO	Viking Automatic Sprinkle at facility on 06-24-2016 to required smoke detectors. All smoke detectors were tested to ensure complian manufacturing specification systems was at facility on Testing of the system was within compliance.	perform the ensitivity test. inspected and ce with ns. Protection 06-30-2016.		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted June 30, 2016

Mr. Steve Fritzke, Administrator Sleepy Eye Care Center 1105 Third Avenue Southwest Sleepy Eye, Minnesota 56085

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5225026

Dear Mr. Fritzke:

The above facility was surveyed on June 13, 2016 through June 16, 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor @ (651) 201-3793.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		
	00776 B. WING			06/16/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	00/10/2010
SLEEPY E	YE CARE CENTER		AVENUE SOUT EYE, MN 56085	HWEST	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been mpliance with all			
	that may result from norders provided that a	earing on any assessments con-compliance with these written request is made to a 15 days of receipt of a for non-compliance.			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

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

(X6) DATE TITLE 07/08/16 Electronically Signed

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE_ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE CARE CENTER 1106 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56985 PROVIDERS R-NA OF CORRECTION (ACA) ID (RACHDERHOESED BY PILL) REGULATORY OR I.S. DIENTIFYING INFORMATION) PREDX RECHORRECTIVE ACTION SHOULD BE CONFIDENCED BY THE RESULATORY OR I.S. DIENTIFYING INFORMATION) 2 000 Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date you orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 23rd, 24th, 25th and 28th 2016, surveyors of this Department of Health. On May 23rd, 24th and 28th 2016, surveyors of this Department of Health will be corrected prior to electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by," Flooking the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000	Department of Health you electronically. Ali is necessary for State enter the word "correct text. You must then in State licensure processompletion date, the corrected prior to elect Minnesota Department of Minnesota Department orders are issued. Plelectronic plan of correviewed these orders they will be completed Minnesota Department the State Licensing C federal software. Tag assigned to Minnesota Nursing Homes. The assigned tag nuncolumn entitled "ID P statute/rule out of con "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following are the Suggested Me Time period for Corre	orders being submitted to though no plan of correction statutes/Rules, please cted" in the box available for dicate in the electronic ass, under the heading date your orders will be ctronically submitting to the not of Health. 25th and 26th 2016, artment's staff, visited the net following correction ease indicate in your rection that you have as, and identify the date when dicate in your rection Orders using numbers have been a state statutes/rules for a state statutes/rules for the refix Tag." The state appliance is listed in the of Deficiencies" column Comply" portion of the column also includes the violation of the state statute This Rule is not met as ang the surveyors findings ethod of Correction and ction. D THE HEADING OF THE WHICH STATES,	2 000					

Minnesota Department of Health

STATE FORM PUED11 If continuation sheet 2 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED		
00776		B. WING			06/16/2016			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SLEEPY E	SLEEPY EYE CARE CENTER 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085							
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		IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.						

Minnesota Department of Health

STATE FORM PUED11 If continuation sheet 3 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
		00776	B. WING		06/1	16/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE			
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SLEEPY E	YE CARE CENTER		YE, MN 56085				
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2 000	Continued From page	e 3	2 000				
		participate in the electronic					
		sure orders consistent with					
	the Minnesota Depart Informational Bulletin						
		te.mn.us/divs/fpc/profinfo/inf					
	obul.htm The State	• •					
	delineated on the atta	ached Minnesota					
	-	orders being submitted to					
		though no plan of correction					
	•	e Statutes/Rules, please					
	enter the word "corrected" in the box available for text. You must then indicate in the electronic						
		ess, under the heading					
	completion date, the date your orders will be corrected prior to electronically submitting to the						
	Minnesota Department of Health.						
	On June 13 through	June 16, 2016, surveyors of					
	_						
	this Department's staff visited the above provider and the following correction orders are issued.						
	Please indicate in you						
		ave reviewed these orders,					
	and identify the date	when they will be completed.					
2 570		Subp. 4 Comprehensive	2 570			7/26/16	
	Plan of Care; Revisio	n					
	Suhn 4 Revision	A comprehensive plan of					
	care must be reviewe						
		that includes the attending					
		ed nurse with responsibility					
		other appropriate staff in					
		ined by the resident's needs,					
	and, to the extent pra						
		sident, the resident's legal					
	guardian or chosen re	- -					
	quarterry and within S	seven days of the revision of					

Minnesota Department of Health

STATE FORM PUED11 If continuation sheet 4 of 25

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
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		00776	B. WING		06/1	6/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SI FFPY F	YE CARE CENTER	1105 3RD	AVENUE SOUT	HWEST		
JLLLF I L	TE CARE CENTER	SLEEPY E	YE, MN 56085			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 570	Continued From page	÷ 4	2 570			
		sident assessment required				
	by: Based on observation review, the facility fail for 1 of 3 residents (R conditions and 1 of 1	residents (R35) reviewed for equipment, which caused		Corrected		
	Findings include:					
	revealed R35 was coudelusions or hallucina rejection of care and assistance of at least (moving between surf	•				
	lying down in bed dur surveyor. On 6/15/16, observed lying in her during random observ 6/14/16, and 6/15/16. providing assistance of R35 explained the nu in April and told her th and R35 would need one week ago, the fact for her to use. R35 re when the nursing ass with her on Sunday it would not fit in her wh	a.m. R35 was observed ing an interview with at 4:01 p.m. R37 was bed, as she had been vation during survey on R35 was asked if staff were to her transfer out of bed. It is staff had spoken to her transfer out of bed. It is staff were not a right fit a new sling. Approximately cility received the new sling ported it was heavy and istants (NA) tried to use it was very uncomfortable and neelchair. R35 explained that lith concerns which made it				

Minnesota Department of Health

STATE FORM PUED11 If continuation sheet 5 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLI	ILED
	00776	B. WING		06/1	6/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SLEEPY EYE CARE CENTER	1105 3RD A	VENUE SOUT	HWEST		
SLEEPT ETE CARE CENTER	SLEEPY E	YE, MN 56085			
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
to well up at this time. In physical therapist or occome in to assess sling nursing assistants had new sling. R35 reported was helping her get out problems with the sling devices used to assist residents. For some medused to hold residents. For some medused to hold residents. On 06/16/2016, at 8:54 nurse working on R35's about R35 not getting of "it's a commotion" and went with certain slings any of them." LPN-A redirector of nursing (DO and instead believed R the conversation with the and oriented. During the DON reported she had new sling and lift with F this assessment. DON had not been out of becasked if the care plan in R35 had trouble adjusting and was spending responded she would in and did not know. On 6/16/16, at 9:56 a.m. assisted R35 out of becasisted R35 out of becasisted R35 out of becasisted R35 out of fit in the converted it did not fit in	ngs in the facility. R35 ught about the whole well up, and was observed R35 reported no nurse, ccupational therapist had g and lift use for her. Only worked with her and the d she felt angry no one t of bed and resolve g. (Mechanical lifts are staff in transferring echanical lifts, a sling is during the transfer.) I a.m. a licensed practical s unit, (LPN)-A, was asked out of bed. LPN-A reported explained that certain lifts and "(R35) does not like exported she did not tell the line in the lift is seported by the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is seporte	2 570			

Minnesota Department of Health

STATE FORM PUED11 If continuation sheet 6 of 25

Minnesota Department of Health

	OF OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06/16/2016	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/10/2010	
SLEEPY E	YE CARE CENTER		AVENUE SOUT			
		SLEEPY E	YE, MN 56085			
(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 SHOUNDER OF THE APPROPRIES OF THE	LD BE COMPLET	ΓE
2 570	Continued From page	e 6	2 570			
	and sling R35 preferralmost tipped. NA-B ron Monday, 6/13/16, the new sling.	ad attempted to use the lift ed to transfer her and it reported she told the DON that R35 had trouble with				
		transfer from 6/13/16, at urveyor intervention on				
	not like either slings v she refused to use to that works with lift and 5-10 mins and insistir sling is uncomfortable have to talk to DON of Review of the progres 6/16/16, revealed no	g. "Resident upset as does we have for her, the new one day and tried the other sling d only sat up in chair for ag to be put back to bed as e. reported that resident will an Monday about slings." as notes for 6/1/16, through assessment or intervention erns with use of new sling or of bed until surveyor				
	her sling until 6/16/16 was modified and rearefusing new sling, strong continue to work with was also revised on 6 "Transfers-requires place (specialized) hoyer lift were assigned to nurs no guidance on how row with resident". Trevised on 6/16/16, to get up daily and resident and resident was modified to get up daily and resident was modified and resident was modified and resident was modified and resident was also revised on 6/16/16, to get up daily and resident was modified and resident was also revised on 6/16/16, to get up daily and resident was modified and resident was also revised on 6/16/16, to get up daily and resident was also revised on 6/16/16, to get up d	to R35's concerns regarding On 6/16/16, the care plan d "Resident has been ating it is uncomfortable. resident." The care plan				

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06/1	6/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
SLEEPY E	YE CARE CENTER	1105 3RD A	AVENUE SOUT	HWEST			
			YE, MN 56085				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
2 570	Continued From page	÷ 7	2 570				
	bed or to review risks There were no interved despite concerns rela approach to use or mocomfortable. There we mitigate the potential bed because of conceskin, comfort, mobility issues. R66's care plan lacke	ethods to make her more ere no interventions to impact of not getting out of erns related to sling, such as r, social and emotional d current skin tear on right					
	area on the left outer Care Plan with revision "Focus: Resident has outer heel. Has the foincontinent of urine, A appetite variesupda pressure ulcer on left will remain intact. Interessistance with repossibility will esitting and required and repositioning ever Res. (resident) does not (overnight) at times. If and Nursing Assistant the Nurse. Keep residence. Alternating air more ducing device for chassessment by Licens care plan lacked curre forearm.	on date 3/24/16, read, a pressure area on left Illowing risk factors: Alzheimer's Dementia, DM, ate res. has unstageable great toe. Goal: The Skin erventions: Requires itioning every 2 hrs (hours) ires assistance with turning ry 4 hrs (hour) while lying. refuse to be turned at noc respect skin daily with cares at to report any concerns to lent's bed linen dry & wrinkle attress for bed. Pressure hair. Weekly skin sed Nurses." However the ent skin tear on right					
	included Alzheimer's Delusional, Hallucinal agitation.	disease, Dementia, tions, restlessness and					

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Minnesota Department of Health STATE FORM

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLLI TAG CONTinued From page 8 Progress note dated 6/11/6, at 2:16 p.m. read, "IDT (interdisciplinary team) team () met to discuss pressure areas on right great toe and left heel. Areas are healed. Continue current interventions." Progress note dated 6/13/16 at 10:39 p.m. indicated, "Skin tear of unknown cause to right forearm. 1.5 cm x 1 cm (centimeter) used steri strips to close and notified all incident report parties and filed va (Vulnerable adult)." Nurses Weekly Wound Documentation dated 6/15/16, at 3:45 p.m. registered nurse (RN)-A stated, weekly wound assessments are done weekly and R66 skin tear measurement on 6/15/16 was 1.2 cm x 0.6 cm. On 6/16/16, at 9:32 a.m. RN-A confirmed R66's care plan lacked current skin tear and indicated R66 has a pressure area on left outer heel. RN-A stated, he expectation is care plan needs to be updated with interventions is care plan needs to be updated with interventions when there is a change or new skin concerns such as skin tears.	STATEMENT	of Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
SLEEPY EYE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS REFERENCED TO THE APPROPRIATE DATE 2 570 Continued From page 8 2 570 Progress note dated 6/1/16, at 2:16 p.m. read, "IDT (interdisciplinary team) team () met to discuss pressure areas on right great toe and left heel. Areas are healed. Continue current interventions." Progress note dated 6/13/16 at 10:39 p.m. indicated, "Skin tear of unknown cause to right forearm. 1.5 cm x 1 cm (centimeter) used steri strips to close and notified all incident report parties and filed va (Vulnerable adult)." Nurses Weekly Wound Documentation dated 6/15/16, at 1:55 p.m. read, "Right arm skin tear 1.2 x 0.6 100% (percent) granulation intact. Continue to monitor until healed." On 6/15/16, at 3:45 p.m. registered nurse (RN)-A stated, weekly wound assessments are done weekly and R66 skin tear measurement on 6/15/16 was 1.2 cm x 0.6 cm. On 6/16/16, at 9:32 a.m. RN-A confirmed R66's care plan lacked current skin tear and indicated R66 has a pressure area on left outer heel. RN-A stated, her expectation is care plan needs to be updated with interventions when there is a change or new skin concerns such as skin tears.			00776	B. WING		06/1	6/2016
(A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 570 Continued From page 8 Progress note dated 6/1/16, at 2:16 p.m. read, "IDT (interdisciplinary team) team () met to discuss pressure areas on right great toe and left heel. Areas are healed. Continue current interventions." Progress note dated 6/13/16 at 10:39 p.m. indicated, "Skin tear of unknown cause to right forearm 1.5 cm x 1 cm (centimeter) used steri strips to close and notified all incident report parties and filed va (Vulnerable adult)." Nurses Weekly Wound Documentation dated 6/15/16, at 1:55 p.m. read, "Right arm skin tear 1.2 x 0.6 100% (percent) granulation intact. Continue to monitor until healed." On 6/15/16, at 3:45 p.m. registered nurse (RN)-A stated, weekly wound assessments are done weekly and R66 skin tear measurement on 6/15/16 was 1.2 cm x 0.6 cm. On 6/16/16, at 9:32 a.m. RN-A confirmed R66's care plan lacked current skin tear and indicated R66 has a pressure area on left outer heel. RN-A stated, her expectation is care plan needs to be updated with interventions when there is a change or new skin concerns such as skin tears.	NAME OF PI	ROVIDER OR SUPPLIER		, ,	,		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 570 Continued From page 8 Progress note dated 6/1/16, at 2:16 p.m. read, "IDT (interdisciplinary team) team () met to discuss pressure areas on right great tote and left heel. Areas are healed. Continue current interventions." Progress note dated 6/13/16 at 10:39 p.m. indicated, "Skin tear of unknown cause to right forearm. 1.5 cm x 1 cm (centimeter) used steri strips to close and notified all incident report parties and filed va (Vulnerable adult)." Nurses Weekly Wound Documentation dated 6/15/16, at 1:55 p.m. read, "Right arm skin tear 1.2 x 0.6 100% (percent) granulation intact. Continue to monitor until healed." On 6/15/16, at 3:45 p.m. registered nurse (RN)-A stated, weekly wound assessments are done weekly and R66 skin tear measurement on 6/15/16 was 1.2 cm x 0.6 cm. On 6/16/16, at 9:32 a.m. RN-A confirmed R66's care plan lacked current skin tear and indicated R66 has a pressure area on left outer heel. RN-A stated, her expectation is care plan needs to be updated with interventions when there is a change or new skin concerns such as skin tears.	SLEEPY EYE CARE CENTER						
Progress note dated 6/1/16, at 2:16 p.m. read, "IDT (interdisciplinary team) team () met to discuss pressure areas on right great toe and left heel. Areas are healed. Continue current interventions." Progress note dated 6/13/16 at 10:39 p.m. indicated, "Skin tear of unknown cause to right forearm. 1.5 cm x 1 cm (centimeter) used steri strips to close and notified all incident report parties and filed va (Vulnerable adult)." Nurses Weekly Wound Documentation dated 6/15/16, at 1:55 p.m. read, "Right arm skin tear 1.2 x 0.6 100% (percent) granulation intact. Continue to monitor until healed." On 6/15/16, at 3:45 p.m. registered nurse (RN)-A stated, weekly wound assessments are done weekly and R66 skin tear measurement on 6/15/16 was 1.2 cm x 0.6 cm. On 6/16/16, at 9:32 a.m. RN-A confirmed R66's care plan lacked current skin tear and indicated R66 has a pressure area on left outer heel. RN-A stated, her expectation is care plan needs to be updated with interventions when there is a change or new skin concerns such as skin tears.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
In addition, RN-A mentioned, R66's pressure area on her left outer heel healed. Policy and procedure titled CARE PLAN POLICY AND PROCEDURE, dated revised 3/2012, and indicated, "9. The care plan is to be changed and updated as the care changes for the resident as the resident changes (Any temporary problems will be added to comprehensive care plan if no resolution in 30 days). It is to be current at all times. It is recommended that the care plan is printed annually."	2 570	Progress note dated 6 "IDT (interdisciplinary discuss pressure area heel. Areas are heale interventions." Progress note dated 6 indicated, "Skin tear of forearm. 1.5 cm x 1 cm strips to close and not parties and filed va (Vanases Weekly Woun 6/15/16, at 1:55 p.m. 1.2 x 0.6 100% (perce Continue to monitor und Con 6/15/16, at 3:45 p. stated, weekly wound weekly and R66 skin 6/15/16 was 1.2 cm x On 6/16/16, at 9:32 at care plan lacked current R66 has a pressure a stated, her expectation updated with intervent change or new skin collin addition, RN-A mer on her left outer heel Policy and procedure AND PROCEDURE, of indicated, "9. The care updated as the care of the resident changes will be added to compresolution in 30 days) times. It is recomment	solutions of the second	2 570			

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Minnesota Department of Health

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	OMPLETED	
		00776	B. WING		06/1	6/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	•		
SLEEPY E	YE CARE CENTER		AVENUE SOUT YE, MN 56085				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
2 570	The director of nursing develop and impleme related to care plan redesignee, could proving staff related to the time revisions. The quality perform random audit TIME PERIOD FOR (21) days.	OD OF CORRECTION: g (DON) or designee, could nt policies and procedures evisions. The DON or de training for all nursing eliness of care plan assurance committee could s to ensure compliance. CORRECTION: Twenty-one	2 570				
2 830	receive nursing care a custodial care, and su individual needs and puthe comprehensive replan of care as descr 4658.0405. A nursing of bed as much as po	eneral. A resident must and treatment, personal and apervision based on preferences as identified in sident assessment and abed in parts 4658.0400 and a home resident must be out assible unless there is a attending physician that the in bed or the resident	2 830			7/26/16	
	by: Based on observation review, the facility failureviewed with a recen equipment (R35) was care and services to s	provided with appropriate successfully meet her sychosocial needs and		Corrected			

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
7.11.2.1.2.11.1			A. BUILDING: _			
		00776	B. WING		06/	16/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1105 3RD	AVENUE SOUT	HWEST		
SLEEPY E	YE CARE CENTER	SLEEPY	EYE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page	e 10	2 830			
	5/7/16, revealed R35 no delusions or hallud to rejection of care ar assistance of at least	two staff for transfers				
	,	face to or from: bed, chair, position, excluding to/from				
	lying down in bed dur surveyor. On 6/15/16	a.m. R35 was observed ing an interview with , at 4:01 p.m. R37 was bed, as she had been				
	6/14/16, and 6/15/16.	vation during survey on R35 was asked if staff were to her transfer out of bed.				
	R35 replied "I plead to	he 5th". R35 explained, after cility staff had told residents				
		d" due to resident complaints				
	April and told her the	staff had spoken to her in slings were not a right fit				
	new sling. Approxima	need to spend \$700 on a tely one week ago, the				
	reported it was heavy	ew sling for her to use. R35 and when the nursing to use it with her on Sunday				
		able and would not fit in her				
		ained that she had physical				
		h made it difficult to use				
	_	ility. R35 reported when she				
	_	ole situation she started to				
		erved to well up at this time.				
		guilty and like she had done				
	spend so much mone	t required the facility to by on a sling for her. R35 f she hoped they got a				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00776	B. WING		06/16/2016	
NAME OF PROMPED OR OURDING			TF 710 000F	1 06/16/2016	
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA VENUE SOUT			
SLEEPY EYE CARE CENTER		E, MN 56085	HWEST		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
know and had to get cosling because it was \$7 unable to bathe the day added she could not get spend time with a family earlier in the day. R35 rassistants had come in emotional in the last few nurse, physical therapis had come in to assess Only nursing assistants the new sling. R35 repowas helping her get out problems with the sling devices used to assist sresidents. For some metused to hold residents of the composition of 15/16, at 4:15 p.m reported they had just a shift. They reported R3 special events. NA-C re R35 assistance out of the shift on 6/14/16, because On 6/16/16, at 8:25 a.m approximately two cent upper coccyx. On 06/16/2016, at 8:54 nurse working on R35's about R35 not getting or "it's a commotion" and owent with certain slings any of them." LPN-A expurchased one for her to complained that it was to severe the complained that it was the complained that it was the content of the complained that it was the content of the co	I they told her they did not orporate approval for the 700. R35 reported she was a prior as scheduled. R35 et out of bed today to by member who visited reported the nursing and saw she was we days. R35 reported no st or occupational therapist sling and lift use for her. Is had worked with her and orted she felt angry no one to fo bed and resolve and the felt in transferring echanical lifts, a sling is during the transfer.) In. NA-C and NA-D arrived for the evening se R35 was "emotional". In. surveyor observed an attimeters long slit on R35's Is a.m. a licensed practical sunit, (LPN)-A, was asked out of bed. LPN-A reported explained that certain lifts and "(R35) does not like explained the facility had that cost \$700 and R35 too big and would not fit in reported she did not tell	2 830			

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
ANDIEAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _		J COWII E	
		00776	B. WING		06/1	6/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SLEEPY E	YE CARE CENTER		AVENUE SOUT			
			YE, MN 56085			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
	initiate the conversati was alert and oriented R35 "my hands are till LPN-A reported she to expensive, but did not the same interview, the assessed the use of the R35 but did not docur reported the open are discovered the day properties. LPN-A reported R35 but wo days. DON and Loying in bed all day im the open area on the the care plan had been	t tell R35 the cost. During the DON reported she had the new sling and lift with ment this assessment. DON the an R35's coccyx was rior, on 6/15/16. DON and thad not been out of bed for PN-A did not believe R35's the pacted the development of coccyx. DON was asked if the nupdated since R35 had				
	was spending more ti she would have to ch not know. At 10:01 a. inappropriate for staff with R35.	me use of the new sling and me in bed. DON responded eck the care plan and did m. DON reported it would be to discuss cost of the sling m. NA-B reported she had ed on Saturday and Sunday.				
	reported it did not fit it too thick. NA-B report recliner was difficult for NA-B reported she to 6/13/16, that R35 had On 6/16/16, at 10:01 assisted R35 to trans R35 readily agreed to	as upset with the sling and in the wheelchair and was sed transferring from bed to or R35 and R35 was upset. Id the DON on Monday, I trouble with the new sling. a.m. NA-A, NA-B and DON fer from her bed to recliner. In have DON assess the felped position R35 in her				
	recliner. R35 reported on the sling in the rec	I it was uncomfortable to sit liner because it was puffing ling between the arms and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE	SURVEY
THE PERIOD CONTROL	IDENTIFICATION NOMBER.	A. BUILDING: _			
	00776	B. WING	·	06	/16/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE		
SLEEPY EYE CARE CENTER		AVENUE SOUT	HWEST		
		EYE, MN 56085			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
a.m. R35 told DON a was a little hot, awkw assistants had adjust tickling her hair. R35 it was just because signification and adjusted to the new signification and awkwa passing trays at the transfer of the conditioner. At 1:58 puncomfortable becaused in the conditioner. At 1:58 puncomfortable. Co	for the time being. At 10:27 and surveyor the new sling ard and the nursing ed the sling earlier as it was reported she did not know if the would have to get sling. At 12:01 a.m. R35 was ner and felt the sling was still ard. The dietary manager, ime, turned on the room air to.m. R35 said she was still se there were boards in the titing up in her recliner. The torders revealed a ed 2/3/16,"Up daily for 2-3 evening shift." There were 35 to remain in bed. If care from May 16th until cast transferred at least once 6. R35 transferred with staff 1-3 times each day on (16; between 2-4 times each cyn 5/29/16; between 2-6 (0/16 through 6/5/16; between 6/6/16 through 6/12/16 (no and 0 -2 times per day 6/16/16 (no transfers from until after surveyor 16 at 10:01 a.m.)	2 830			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		00776	B. WING		06/1	6/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SLEEPY E	YE CARE CENTER		AVENUE SOUT YE, MN 56085			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
2 830	Continued From page	e 14	2 830			
	tasks were assigned to was no guidance on he to "work with resident revised on 6/16/16, to to get up daily and reprefers to stay in bedguidance on handling bed or to review risks. There were no interved despite concerns related approach to use or me comfortable. There we mitigate the potential bed because of concerns.	er lift for transfers." These to nursing assistants. There now nursing assistants were ". The care plan was also o note "Encourage resident position/offload. Resident -Refuses." There was no R35's refusal to get out of and benefits of this refusal. entions to get her out of bed ted to sling, such as ethods to make her more ere no interventions to impact of not getting out of erns related to sling, such as a social and emotional				
	not like either slings washe refused to use too that works with lift and 5-10 mins and insisting sling is uncomfortable have to talk to DON or Review of the progres 6/16/16, revealed no related to R35's conceparriers to getting out intervention on 6/16/10. Progress note, dated "coccyx-Pressure: Le Depth=0, Stage II Opskin assessment, date concerns. A progress scanned and emailed the survey. The note	g "Resident upset as does we have for her, the new one day and tried the other sling d only sat up in chair for ng to be put back to bed as e, reported that resident will on Monday about slings." as notes for 6/1/16 through assessment or intervention erns with use of new sling or of bed until surveyor 6, at 10:16 a.m.				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE S COMPL	
		00776	B. WING		06/1	6/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	-	
SLEEPY EYE CARE CENTER			AVENUE SOUT YE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	e 15	2 830			
	time. Area determined incontinence, not pres					
	director of nursing [Do [LSW] or designee condevelop a procedure changes and concern and concerns to the afollowing up on change LSW or designee couprocedure. DON and audit for continued conto the quality assurant	ges and concerns. DON and all educate all staff on this LSW or designee could ampliance and report results				
21805	MN St. Statute 144.66 Residents of HC Fac. Subd. 5. Courteous residents have the rig courtesy and respect	Bill of Rights treatment. Patients and	21805			7/26/16
	by: Based on observation review, the facility fail for 1 of 1 resident (R3 over two days and ex and anger due to com	r specialized equipment and		Corrected		

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	
7.11.2.1.2.11.1	5. GGTLGTGT.		A. BUILDING: _	A. BUILDING:		
		00776	B. WING		06/	16/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1105 3RD	AVENUE SOUT	HWEST		
SLEEPY E	YE CARE CENTER	SLEEPY I	YE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED ⁻ DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21805	Continued From page	e 16	21805			
	Findings include:					
	Findings include.					
	5/7/16, revealed R35 no delusions or hallud to rejection of care ar assistance of at least (moving between surface).	um data set (MDS) dated was cognitively intact, had cinations, behaviors related and required extensive two staff for transfers face to or from: bed, chair, position, excluding to/from				
	On 6/14/16, at 10:25 a.m. R35 was observed lying down in bed during an interview with surveyor. On 6/15/16, at 4:01 p.m. R37 was observed lying in her bed, as she had been during random observation during survey on 6/14/16, and 6/15/16. R35 was asked if staff were providing assistance to her transfer out of bed. R35 replied "I plead the 5th". R35 explained, after a previous survey, facility staff had told residents the facility got "dinged" due to resident complaints and so she was hesitant to complain. R35 explained the nursing staff had spoken to her in April and told her the slings were not a right fit and the facility would need to spend \$700 on a new sling. Approximately one week ago, the facility received the new sling for her to use. R35					
	assistants (NA) tried it was very uncomfort wheelchair. R35 explahealth concerns which other slings in the fact had tried to transfer hand it almost tipped. It thought about the whowell up, and was observable reported she felt something wrong that	and when the nursing to use it with her on Sunday table and would not fit in her ained that she had physical h made it difficult to use willity. R35 reported the staff are with another lift and sling R35 reported when she cole situation she started to erved to well up at this time. It is guilty and like she had done to required the facility to easy on a sling for her. R35				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION		3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
		00776	B. WING		06/1	6/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-		
		1105 3RD A	VENUE SOUT	HWEST			
SLEEPY E	SLEEPY EYE CARE CENTER SLEEPY E						
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21805	Continued From page	e 17	21805				
2.000	reported she told staff refund on the sling and know and had to get of sling because it was so not get out of bed tood family member who was was emotion reported the nursing as saw she was emotion reported no nurse, phoccupational therapis sling and lift use for had worked with her are reported she felt angreget out of bed and resulting. At 1:58 p.m. R3 member and a busine her the cost of the nedevices used to assis	f she hoped they got a and they told her they did not corporate approval for the 5700. R35 added she could any to spend time with a sisited earlier in the day. R35 assistants had come in and all in the last few days. R35 ysical therapist or thad come in to assess er. Only nursing assistants and the new sling. R35 y no one was helping her solve problems with the 5 reported a nursing staff ess staff member had told w sling. (Mechanical lifts are t staff in transferring nechanical lifts, a sling is					
	nurse working on R38 about R35 not getting "it's a commotion" and went with certain sling any of them." LPN-A purchased one for he complained that it wa R35's wheelchair. LP the director of nursing concern and instead linitiate the conversati was alert and oriented R35 "my hands are till LPN-A reported she to expensive, but did no the same interview, the assessed the use of the same same interview.	pelieved R35 would have to on with the DON as R35 d. LPN-A reported she told ed, this is what I have."					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. Bolebino.			
		00776	B. WING		06/16/201	16
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SLEEPY E	YE CARE CENTER		AVENUE SOUT YE, MN 56085			
0(0.15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECT	TON	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE COM	(X5) MPLETE DATE
21805	Continued From page	2 18	21805			
	for two days. At 10:01	R35 had not been out of bed a.m. DON reported it would taff to discuss cost of the				
		transfer from 6/13/16, at urveyor intervention on				
	not like either slings v she refused to use to that works with lift and 5-10 mins and insistir sling is uncomfortable have to talk to DON of Review of the progres 6/16/16, revealed no	y "Resident upset as does we have for her, the new one day and tried the other sling d only sat up in chair for ag to be put back to bed as e, reported that resident will an Monday about slings." as notes for 6/1/16, through assessment or intervention erns with use of new sling or of bed until surveyor				
		plan revealed no to R35's concerns regarding , after surveyor intervention.				
	director of nursing [Dotate of procedure on appropriate of procedure on appropriate of the procedure on appropriate of the procedure on appropriate of the procedure of the proc	OD OF CORRECTION: The ON] and social worker old develop a policy and riate interactions with presidents with dignity and d LSW or designee could appropriate interactions with presidents with dignity and W or designee could audit nce and report results to the				

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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	
		00776	B. WING		06/16/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
SLEEPY E	YE CARE CENTER		AVENUE SOUT YE, MN 56085		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21805	Continued From page	e 19	21805		
	facility quality assurar	nce committee.			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one			
21810	MN St. Statute 144.69 Residents of HC Fac.		21810		7/26/16
	residents shall have the medical and personal needs. Appropriate coare designed to enall highest level of physical This right is limited where the medical properties are the medical properties.	te health care. Patients and he right to appropriate care based on individual are for residents means ble residents to achieve their cal and mental functioning. here the service is not c or private resources.			
	by: Based on observation review, facility failed t	t is not met as evidenced n, interview and document o ensure call light was within ent (R97) dependent on staff		Corrected	
	reach if she needed a located hanging from floor next to R97's be was walking down the room. R97 was seate door. RN-A verified ca draped call light cord R97, and clipped it to R97 if she could push pushed red button. W	.m. during resident as not observed within R97's assistance from staff. It was wall call light box onto the d. Registered nurse (RN)-A e hall and came into R97's d in wheelchair next to room all light was not within reach, over bed, brought it over to her sweater. RN-A asked a red call light and R97 l'hen asked if R97 could use ated she "uses button at			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00776	B. WING		06	6/16/2016
	ROVIDER OR SUPPLIER	1105 3R	ADDRESS, CITY, STAT D AVENUE SOUTH 'EYE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21810	Continued From page		21810			
	times and does need it."	it to be there for her to use				
	R97's face sheet included unspecified sequelae generalized muscle w	of cerebral infarction and				
	R97's care plan dated 6/6/16, activities of daily living interventions included physical assist of one with wheelchair, physical assist of one with walker, and monitor for assist with transfers.					
		.m. director of nursing ectation was that call light ent to reach it.				
	2006, indicated "11. E	s call light use policy dated Be sure call lights are placed at all times, never on the d."				
	administrator, directo could assure that poli revised, up to date, ir	OD OF CORRECTION: The r of nursing or designee cies and procedures are nplemented and monitored II lights are within reach and are met.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty One				
21830	MN St. Statute 144.6 Residents of HC Fac.	51 Subd. 10 Patients & Bill of Rights	21830			7/26/16
	Subd. 10. Participar notification of family r	tion in planning treatment; nembers.				
	(a) Residents shall h	nave the right to participate				

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WIIIIIICSOL	a Department of Fleatti	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00776	B. WING		06/1	6/2016
NAME ∩E PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		Ì
NAME OF TH	TOVIDER OR SOLT LIER					
SLEEPY E	YE CARE CENTER		VENUE SOUT	HWEST		
		SLEEPY E	YE, MN 56085			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	1,710	DEFICIENCY)		
24020	0 " 15	0.4	04000			
21830	Continued From page	2 21	21830			
		r health care. This right				
	• • •	ity to discuss treatment and				
	alternatives with indiv	•				
	opportunity to request	t and participate in formal				
	care conferences, and	d the right to include a				
	family member or other	er chosen representative or				
	both. In the event that	t the resident cannot be				
	present, a family men	nber or other representative				
	chosen by the resider	nt may be included in such				
	conferences.					
	(b) If a resident who	o enters a facility is				
	unconscious or coma	tose or is unable to				
	communicate, the fac	ility shall make reasonable				
	efforts as required und	der paragraph (c) to notify				
	either a family member	er or a person designated in				
	writing by the resident	t as the person to contact in				
	an emergency that the	e resident has been				
	admitted to the facility	 The facility shall allow the 				
	family member to part	ticipate in treatment				
	planning, unless the fa	acility knows or has reason				
	to believe the residen	t has an effective advance				
		ry or knows the resident has				
		at they do not want a family				
		eatment planning. After				
		nber but prior to allowing a				
	family member to part	•				
	planning, the facility n					
	efforts, consistent with					
	practice, to determine					
		directive relative to the				
		decisions. For purposes of				
		onable efforts" include:				
	()	ersonal effects of the				
	resident;					
		nedical records of the				
	resident in the posses					
		emergency contact or				
		cted under this section				
	whether the resident h	nas evecuted an advance	1			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06/16/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OLEEDV E	VE CARE CENTER	1105 3RD A	VENUE SOUT	HWEST		
SLEEPTE	YE CARE CENTER	SLEEPY E	YE, MN 56085			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
21830	Continued From page	22	21830			
	directive and whether physician to whom the care; and (4) inquiring of the resident normally goe whether the resident directive. If a facility is designated emergency member to participate accordance with this liable to resident for different the notification of the emergency contact of family member was in patient's privacy right. (c) In making reason family members or a design examining the person and the medical recompossession of the fact to notify a family memergency contact whe admission, the facility social service agency agency that the resident the facility has been under the member or designate county social service enforcement agency identifying and notifying designated emergency service agency or loce that assists a facility subdivision is not liab	the resident has a e resident normally goes for physician to whom the so for care, if known, has executed an advance notifies a family member or cy contact or allows a family in paragraph, the facility is not lamages on the grounds that family member or the participation of the improper or violated the solonable efforts to notify a signated emergency contact, upt to identify family atted emergency contact by the leffects of the resident reds of the resident in the sility. If the facility is unable in the shall notify the county or local law enforcement ent has been admitted and unable to notify a family demergency contact. The agency and local law shall assist the facility in ing a family member or cy contact. A county social all law enforcement agency in implementing this le to the resident for				
	the family member or	nds that the notification of emergency contact or the mily member was improper				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06/16	5/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SLEEPY E	EYE CARE CENTER		AVENUE SOUT			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
21830	Continued From page	23	21830			
	or violated the patient	's privacy rights.				
	by: Based on interview ar facility failed to asses	t is not met as evidenced and document review, the s bathing frequency resident reviewed for		Corrected		
	Findings include:					
	revealed R7 had seve					
	phone on 6/14/16, at used to shower at lea home. F-A reported s frequently R7 was ba 6/15/16, at 2:29 p.m. with R7 in his room. F asked her about how bathe each week and R7 or another family was getting bathed at while at home and wo bathe R7 at least twic trouble remembering bathing schedule.	thed at the facility. On F-A was observed visiting F-A reported no one had many times R7 would like to was unsure if staff asked member. F-A reported R7 least 2-3 times each week ould expect the facility would be each week. R7 had and reporting his prior				
	(DON) reported the badetermined by room rescheduled once a week	.m. the director of nursing athing schedule was number and residents were ek. A resident would need to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00776	B. WING		06	6/16/2016
	ROVIDER OR SUPPLIER	1105 3RD /	ORESS, CITY, STA AVENUE SOUT YE, MN 56085	HWEST		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21830	once each week. R7 veach week. At 3:08 p. no system to assess of bathing times resid There was no docume preferences of R7. On 6/15/16, at 3:16 p (LSW)-A reported the system related to ass preferences. Review of the bath air revealed R7 was schebathing once each we care bathing informative revealed R7 was bath 6/5 and 6/12. SUGGESTED METH director of nursing [D0 [LSW] or designee coensure resident daily including bathing preferences and impedesignee could educate resident choices. DOI could audit for continuesults to the facility of the system of the sy	was getting bathed once .m. DON reported there was and document the number ents wanted each week. entation about the bathing	21830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00776	B. WING		06/1	6/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SLEEPY E	YE CARE CENTER		AVENUE SOUT YE, MN 56085			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not corrected not corrected shall be with a schedule of finithe Minnesota Depart. Determination of whe corrected requires correquirements of the minumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessmit.	ther a violation has been				
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.				
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic sure orders consistent with tment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf icensing orders are				

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

(X6) DATE TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06	6/16/2016
	ROVIDER OR SUPPLIER	1105 3RI	DDRESS, CITY, STATE D AVENUE SOUTH EYE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	you electronically. Al is necessary for State enter the word "corre text. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Departme On May 23rd, 24th, 2 surveyors of this Departme of this Departme of the provider and the orders are issued. Per electronic plan of confere well these orders they will be complete of the State Licensing of the St	orders being submitted to though no plan of correction e Statutes/Rules, please cted" in the box available for indicate in the electronic iss, under the heading date your orders will be ctronically submitting to the int of Health. 25th and 26th 2016, partment's staff, visited the interpretation of the following correction lease indicate in your rection that you have is, and identify the date when id. and of Health is documenting correction Orders using numbers have been it a state statutes/rules for in the far left in the interpretation of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and incition. Difficulty in the document in the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and incition.	2 000			
		OF CORRECTION." THIS AL DEFICIENCIES ONLY.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
		00776	B. WING		06/10	6/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SLEEPY E	YE CARE CENTER		VENUE SOUT (E, MN 56085			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
2 000	Continued From page	2	2 000			
	THIS WILL APPEAR	ON EACH PAGE.				
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		COMPLETED	
		00776	B. WING		06/16/2016		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
SLEEPY E	YE CARE CENTER		AVENUE SOUT				
			YE, MN 56085				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
2 000	Continued From page 3		2 000				
2 570	receipt of State licens the Minnesota Depart Informational Bulletin http://www.health.statobul.htm The State I delineated on the atta Department of Health you electronically. Ali is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department"s state and the following correction that you has and identify the date of MN Rule 4658.0405 SPlan of Care; Revision. Subp. 4. Revision. Care must be reviewed interdisciplinary team physician, a registere for the resident, and of disciplines as determinand, to the extent praparticipation of the residuardian or chosen reguardian or chosen regua	14-01, available at the mn.us/divs/fpc/profinfo/inficensing orders are sched Minnesota orders being submitted to though no plan of correction a Statutes/Rules, please cted" in the box available for dicate in the electronic as, under the heading date your orders will be ctronically submitting to the ent of Health. Sune 16, 2016, surveyors of a ff visited the above provider ection orders are issued. The electronic plan of the electro	2 570				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		00776	B. WING		06/	16/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 00.	10/2010
			AVENUE SOUT	,		
SLEEPY E	EYE CARE CENTER	SLEEPY E	YE, MN 56085			
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 570	2 570 Continued From page 4					
	the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.		2 570			
	by: Based on observation review, the facility fail for 1 of 3 residents (R conditions and 1 of 1 a change in transfer either concern and disconstructions include: R35's minimum data arevealed R35 was condelusions or hallucina rejection of care and massistance of at least (moving between surfi	residents (R35) reviewed for equipment, which caused omfort. set (MDS), dated 5/7/16, gnitively intact, had no required extensive				
	lying down in bed dur surveyor. On 6/15/16, observed lying in her during random observ 6/14/16, and 6/15/16. providing assistance to R35 explained the nur in April and told her thand R35 would need one week ago, the factor her to use. R35 rewhen the nursing ass with her on Sunday it would not fit in her who	a.m. R35 was observed ing an interview with at 4:01 p.m. R37 was bed, as she had been vation during survey on R35 was asked if staff were to her transfer out of bed. rsing staff had spoken to her ne slings were not a right fit a new sling. Approximately cility received the new sling ported it was heavy and istants (NA) tried to use it was very uncomfortable and neelchair. R35 explained that oth concerns which made it				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLI	ILED
	00776	B. WING		06/1	6/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SLEEPY EYE CARE CENTER	1105 3RD A	VENUE SOUT	HWEST		
SLEEPT ETE CARE CENTER	SLEEPY E	YE, MN 56085			
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
to well up at this time. In physical therapist or occome in to assess sling nursing assistants had new sling. R35 reported was helping her get out problems with the sling devices used to assist residents. For some medused to hold residents. For some medused to hold residents. On 06/16/2016, at 8:54 nurse working on R35's about R35 not getting of "it's a commotion" and went with certain slings any of them." LPN-A redirector of nursing (DO and instead believed R the conversation with the and oriented. During the DON reported she had new sling and lift with F this assessment. DON had not been out of becasked if the care plan in R35 had trouble adjusting and was spending responded she would in and did not know. On 6/16/16, at 9:56 a.m. assisted R35 out of becasisted R35 out of becasisted R35 out of becasisted R35 out of fit in the converted it did not fit in	ngs in the facility. R35 ught about the whole well up, and was observed R35 reported no nurse, ccupational therapist had g and lift use for her. Only worked with her and the d she felt angry no one t of bed and resolve g. (Mechanical lifts are staff in transferring echanical lifts, a sling is during the transfer.) I a.m. a licensed practical s unit, (LPN)-A, was asked out of bed. LPN-A reported explained that certain lifts and "(R35) does not like exported she did not tell the line in the lift is seported by the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is son the lift is seported she did not tell the lift is seporte	2 570			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			
		00776	B. WING		06	6/16/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	. ZIP CODE	, ,	
			D AVENUE SOUTH			
SLEEPY E	YE CARE CENTER		EYE, MN 56085			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 570	570 Continued From page 6		2 570			
	NA-B reported she had attempted to use the lift and sling R35 preferred to transfer her and it almost tipped. NA-B reported she told the DON on Monday, 6/13/16, that R35 had trouble with the new sling. Review of the point of care for transferring revealed R35 did not transfer from 6/13/16, at 9:26 p.m. until after surveyor intervention on 6/16/16, at 10:01 a.m. Review of progress notes, dated 6/12/16, revealed the following. "Resident upset as does not like either slings we have for her, the new one she refused to use today and tried the other sling that works with lift and only sat up in chair for 5-10 mins and insisting to be put back to bed as sling is uncomfortable. reported that resident will have to talk to DON on Monday about slings." Review of the progress notes for 6/1/16, through 6/16/16, revealed no assessment or intervention related to R35's concerns with use of new sling or barriers to getting out of bed until surveyor intervention on 6/16/16, at 10:16 a.m.					
	her sling until 6/16/16 was modified and rearefusing new sling, st Continue to work with was also revised on 6 "Transfers-requires p (specialized) hoyer lif were assigned to nur no guidance on how a "work with resident"." revised on 6/16/16, to to get up daily and re	to R35's concerns regarding 6. On 6/16/16, the care plan d "Resident has been ating it is uncomfortable. n resident." The care plan				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COMPLET	
		00776	B. WING		06/1	6/2016
	ROVIDER OR SUPPLIER	1105 3RD A	RESS, CITY, STA VENUE SOUT (E, MN 56085			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 570	bed or to review risks. There were no interved despite concerns rela approach to use or momentable. There were mitigate the potential bed because of conceskin, comfort, mobility issues. R66's care plan lacker forearm and indicated area on the left outer. Care Plan with revision "Focus: Resident has outer heel. Has the forearm intervention of urine, A appetite varies.—update pressure ulcer on left will remain intact. Intervention intervention of the will remain intact. Intervention of the will remain intervention of the will remain intervention of the will rem	R35's refusal to get out of and benefits of this refusal. entions to get her out of bed ted to sling, such as ethods to make her more ere no interventions to impact of not getting out of erns related to sling, such as related to sling, such as resocial and emotional description of the thick that R66 had pressure heel. On date 3/24/16, read, a pressure area on left allowing risk factors: alzheimer's Dementia, DM, atter es. has unstageable great toe. Goal: The Skin erventions: Requires itioning every 2 hrs (hours) ires assistance with turning ry 4 hrs (hour) while lying. refuse to be turned at noc enspect skin daily with cares at to report any concerns to dent's bed linen dry & wrinkle attress for bed. Pressure nair. Weekly skin sed Nurses." However the	2 570			
	forearm. R66's admission record with diagnosis which included Alzheimer's disease, Dementia, Delusional, Hallucinations, restlessness and agitation.					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		00776	B. WING		06/1	6/2016
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SLEEPY E	YE CARE CENTER		VENUE SOUT			
			E, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 570	Continued From page	8	2 570			
	Progress note dated 6 "IDT (interdisciplinary discuss pressure area heel. Areas are healer interventions." Progress note dated 6 indicated, "Skin tear of forearm. 1.5 cm x 1 cm strips to close and not parties and filed va (V Nurses Weekly Woun 6/15/16, at 1:55 p.m. of 1.2 x 0.6 100% (perce Continue to monitor u On 6/15/16, at 3:45 p. stated, weekly wound weekly and R66 skin of 6/15/16 was 1.2 cm x On 6/16/16, at 9:32 a. care plan lacked current R66 has a pressure a stated, her expectation updated with intervent change or new skin collinated in the policy and procedure AND PROCEDURE, of indicated, "9. The care updated as the care of the resident changes will be added to compresolution in 30 days)	s/1/16, at 2:16 p.m. read, team) team () met to as on right great toe and left d. Continue current s/13/16 at 10:39 p.m. of unknown cause to right m (centimeter) used stericified all incident report fulnerable adult)." d Documentation dated read, "Right arm skin tear ent) granulation intact. Intil healed." m. registered nurse (RN)-A assessments are done tear measurement on 0.6 cm. m. RN-A confirmed R66's ent skin tear and indicated rea on left outer heel. RN-A is care plan needs to be tions when there is a oncerns such as skin tears. Intil needs to set to the other strength and skin tears.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06/16/2016
	ROVIDER OR SUPPLIER	1105 3RD A	RESS, CITY, STA AVENUE SOUT YE, MN 56085		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 570	The director of nursin develop and impleme related to care plan redesignee, could provistaff related to the tim revisions. The quality perform random audit	OD OF CORRECTION: g (DON) or designee, could nt policies and procedures evisions. The DON or de training for all nursing	2 570		
2 830	2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.		2 830		
	by: Based on observation review, the facility fail reviewed with a recer equipment (R35) was care and services to services to services.	provided with appropriate successfully meet her sychosocial needs and			

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00776	B. WING		06/16/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		1105 3RD A	VENUE SOUT	HWEST		
SLEEPY E	YE CARE CENTER		YE, MN 56085			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	ETE
2 830	Continued From page	: 10	2 830			
	Findings include: Review of the minimus 5/7/16, revealed R35 no delusions or halluctorejection of care an assistance of at least (moving between surf wheelchair, standing bath/toilet). On 6/14/16, at 10:25 lying down in bed dur surveyor. On 6/15/16 observed lying in her during random observed following assistance of R35 replied "I plead that a previous survey, fact the facility got "dinged and so she was hesite explained the nursing April and told her the and the facility would new sling. Approximatacility received the nursing facility re	m data set (MDS), dated was cognitively intact, had cinations, behaviors related and required extensive two staff for transfers face to or from: bed, chair, position, excluding to/from a.m. R35 was observed ing an interview with at 4:01 p.m. R37 was bed, as she had been vation during survey on R35 was asked if staff were to her transfer out of bed. The 5th. R35 explained, after cility staff had told residents and to complain. R35 staff had spoken to her in slings were not a right fit need to spend \$700 on a tely one week ago, the ew sling for her to use. R35				
	assistants (NA) tried t	and when the nursing to use it with her on Sunday able and would not fit in her				
	wheelchair. R35 explate health concerns which other slings in the fact thought about the who well up, and was observable R35 reported she felt	ained that she had physical in made it difficult to use lilty. R35 reported when she pole situation she started to erved to well up at this time. guilty and like she had done				
	spend so much mone	required the facility to y on a sling for her. R35 f she hoped they got a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06	/16/2016
	ROVIDER OR SUPPLIER EYE CARE CENTER	1105 3RE	DDRESS, CITY, STATE AVENUE SOUTH EYE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD S		
2 830	know and had to get a sling because it was sunable to bathe the dadded she could not a spend time with a famearlier in the day. R35 assistants had come emotional in the last finurse, physical theraphad come in to asses Only nursing assistant the new sling. R35 rewas helping her get oproblems with the slind devices used to assist residents. For some rused to hold residents. On 6/15/16, at 4:15 preported they had justiff. They reported R special events. NA-C R35 assistance out of shift on 6/14/16, because on 6/16/16, at 8:25 a approximately two ceupper coccyx. On 06/16/2016, at 8:5 not getting "it's a commotion" and went with certain sling any of them." LPN-A purchased one for he complained that it was	d they told her they did not corporate approval for the 6700. R35 reported she was ay prior as scheduled. R35 get out of bed today to nilly member who visited or reported the nursing in and saw she was ew days. R35 reported no poist or occupational therapist is sling and lift use for her. It is had worked with her and ported she felt angry no one out of bed and resolve ing. (Mechanical lifts are it staff in transferring in nechanical lifts, a sling is a during the transfer.) I.M. NA-C and NA-D it arrived for the evening it is a during the evening in use R35 was "emotional". I.M. surveyor observed an intimeters long slit on R35's intimeters long and rot like explained the facility had in that cost \$700 and R35 is too big and would not fit in A reported she did not tell	2 830			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING: _			
		00776	B. WING		06	/16/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
SLEEPYE	YE CARE CENTER	1105 3RD	AVENUE SOUT	HWEST		
		SLEEPY	EYE, MN 56085			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	2 830 Continued From page 12		2 830			
	initiate the conversation was alert and oriented R35 "my hands are tied LPN-A reported she to expensive, but did not the same interview, the assessed the use of the R35 but did not docur reported the open are discovered the day properties. The control of the care plan had been trouble adjusting to the was spending more tied she would have to chance the care plan had been trouble adjusting to the was spending more tied the care plan had been trouble adjusting to the was spending more tied the care plan had been trouble adjusting to the would have to chance the care plan had been trouble adjusting to the would have to chance the care plan had been trouble adjusting to the would have to chance the care plan had been trouble adjusting to the would have to chance the care plan had been trouble adjusting to the would have to chance the care plan had been trouble adjusting to the world have to chance the care plan had been trouble adjusting to the world have to chance the care plan had been trouble adjusting to the world have to chance the care plan had been trouble adjusting to the world have to chance the care plan had been trouble adjusting to the world have to chance the care plan had been trouble adjusting to the world have to chance the care plan had been trouble adjusting to the world had been trouble adj	pelieved R35 would have to on with the DON as R35 d. LPN-A reported she told ed, this is what I have." old R35 the sling was tell R35 the cost. During he DON reported she had he new sling and lift with ment this assessment. DON as on R35's coccyx was ior, on 6/15/16. DON and had not been out of bed for PN-A did not believe R35's pacted the development of coccyx. DON was asked if en updated since R35 had e use of the new sling and me in bed. DON responded eck the care plan and did m. DON reported it would be to discuss cost of the sling				
	assisted R35 out of be NA-B reported R35 w reported it did not fit it too thick. NA-B report recliner was difficult for NA-B reported she tol 6/13/16, that R35 had On 6/16/16, at 10:01 assisted R35 to transfer R35 readily agreed to transfer. All three staff recliner. R35 reported on the sling in the rec	m. NA-B reported she had ed on Saturday and Sunday. as upset with the sling and in the wheelchair and was ed transferring from bed to or R35 and R35 was upset. In the DON on Monday, it trouble with the new sling. a.m. NA-A, NA-B and DON fer from her bed to recliner. In the half of the half of the helped position R35 in her at was uncomfortable to sit liner because it was puffing ling between the arms and the freported it was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		00776	B. WING		06	/16/2016
	ROVIDER OR SUPPLIER	1105 3RI	DDRESS, CITY, STATE D AVENUE SOUTH EYE, MN 56085			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO		
2 830	a.m. R35 told DON at was a little hot, awkw assistants had adjusted tickling her hair. R35 it was just because stadjusted to the new still sitting in her reclinal little hot and awkwa passing trays at the ticonditioner. At 1:58 puncomfortable becausing. R35 was still sittle Review of R35's curre prescriber order, date hours every day and no orders directing R38. Review of the point of June 16th revealed Reach day, until 6/10/1 assistance between 15/16/16 through 5/22/day on 5/23/16 through times per day on transfers on 6/10/16) between 6/13/16 and 6/13/16 at 9:26 p.m. Unintervention on 6/16/16 Review of R35's care interventions related ther sling until 6/16/16 On 6/16/16, the care "Resident has been reis uncomfortable. Cor The care plan was also	or the time being. At 10:27 and surveyor the new sling ard and the nursing ed the sling earlier as it was reported she did not know if the would have to get ling. At 12:01 a.m. R35 was ther and felt the sling was still ard. The dietary manager, there, turned on the room air the dietary manager, there were boards in the ting up in her recliner. The torders revealed a and 2/3/16,"Up daily for 2-3 there were boards in the ting up in her recliner. There were and to the troom air the ting up in her recliner. There were and 2/3/16, "Up daily for 2-3 there were at least once and 2/3/16, "Up daily for 2-3 there were at least once and 3.5 transferred at least once and 3.5 transferred at least once by 1.6 through 6/5/16; between by 1.6 through 6/12/16 (no and 0 -2 times per day by 1.6 (no transfers from antil after surveyor by 1.6 at 10:01 a.m.)	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00776	B. WING		06	6/16/2016
	ROVIDER OR SUPPLIER	1105 3RI	DDRESS, CITY, STATE D AVENUE SOUTH EYE, MN 56085			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	tasks were assigned was no guidance on he to "work with resident revised on 6/16/16, to get up daily and reprefers to stay in bed guidance on handling bed or to review risks. There were no interved despite concerns related approach to use or me comfortable. There we mitigate the potential bed because of concerns.	rer lift for transfers." These to nursing assistants. There now nursing assistants were "." The care plan was also note "Encourage resident position/offload. Resident -Refuses." There was no part of the sand benefits of this refusal. The entions to get her out of the sand benefits	2 830			
	not like either slings washe refused to use to that works with lift and 5-10 mins and insisting sling is uncomfortable have to talk to DON or Review of the progres 6/16/16, revealed no related to R35's concident barriers to getting out intervention on 6/16/16 Progress note, dated "coccyx-Pressure: Led Depth=0, Stage II Opskin assessment, dat concerns. A progress scanned and emailed the survey. The note	g "Resident upset as does we have for her, the new one day and tried the other sling d only sat up in chair for ng to be put back to bed as e, reported that resident will on Monday about slings." as notes for 6/1/16 through assessment or intervention erns with use of new sling or of bed until surveyor 16, at 10:16 a.m.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06/16/2016	
	ROVIDER OR SUPPLIER	1105 3RD A	PRESS, CITY, STANAVENUE SOUT YE, MN 56085	,		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	director of nursing [Di [LSW] or designee co develop a procedure changes and concern and concerns to the a following up on chang LSW or designee cou procedure. DON and audit for continued co to the quality assuran	OD OF CORRECTION: The ON] and social worker and review, revise and/or for monitoring residents for its, communicating changes appropriate staff and ges and concerns. DON and all deducate all staff on this LSW or designee could impliance and report results ce committee.	2 830			
21805	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21805 MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide dignified care for 1 of 1 resident (R35) who remained in bed for over two days and experienced feelings of guilt and anger due to comments made by staff regarding her need for specialized equipment and staff failure to follow up on her concerns.		21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		' '	(3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
		00776	B. WING		06/1	6/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CI EEDV E	YE CARE CENTER	1105 3RD A	VENUE SOUT	HWEST			
SLEEPTE	TE CARE CENTER	SLEEPY EY	YE, MN 56085				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
21805	Continued From page	e 16	21805				
	Findings include:						
	Findings include.						
	5/7/16, revealed R35 no delusions or hallud to rejection of care ar assistance of at least (moving between surf	•					
	lying down in bed dur surveyor. On 6/15/16 observed lying in her during random observed lying in her 6/14/16, and 6/15/16. providing assistance R35 replied "I plead the facility got "dinged and so she was hesite explained the nursing April and told her the and the facility would new sling. Approximate facility received the nursing twas very uncomfort wheelchair. R35 explained to transfer head tried to transfer hand it almost tipped. It thought about the whowell up, and was observed.	yat 4:01 p.m. R37 was bed, as she had been yation during survey on R35 was asked if staff were to her transfer out of bed. The 5th". R35 explained, after cility staff had told residents did due to resident complaints ant to complain. R35 staff had spoken to her in slings were not a right fit need to spend \$700 on a tely one week ago, the ew sling for her to use. R35 and when the nursing to use it with her on Sunday table and would not fit in her tained that she had physical the made it difficult to use ility. R35 reported the staff er with another lift and sling R35 reported when she ole situation she started to the staff					
	something wrong that	guilty and like she had done required the facility to y on a sling for her. R35					

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			B. WING			
		00776	B. WING		06/1	6/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SI FFPY F	YE CARE CENTER	1105 3RD /	AVENUE SOUT	THWEST		
		SLEEPY E	YE, MN 56085			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21805	refund on the sling ar know and had to get of sling because it was so not get out of bed tood family member who vereported the nursing as saw she was emotion reported no nurse, phoccupational therapis sling and lift use for had worked with her areported she felt angreget out of bed and resulting. At 1:58 p.m. R3 member and a busine her the cost of the nedevices used to assis residents. For some rused to hold residents. On 06/16/2016, at 8:5 nurse working on R35 about R35 not getting "it's a commotion" and went with certain sling any of them." LPN-A purchased one for he complained that it wa R35's wheelchair. LP the director of nursing concern and instead linitiate the conversati was alert and oriented R35 "my hands are till LPN-A reported she to	If she hoped they got a and they told her they did not corporate approval for the \$700. R35 added she could ay to spend time with a isited earlier in the day. R35 assistants had come in and hal in the last few days. R35 hysical therapist or thad come in to assess er. Only nursing assistants and the new sling. R35 hy no one was helping her solve problems with the resolve problems	21805	DEFICIENCY		
	assessed the use of t	ne DON reported she had he new sling and lift with ment this assessment. DON				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00776	B. WING		06	6/16/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
SLEEPY E	EYE CARE CENTER		AVENUE SOUTH EYE, MN 56085	WEST		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	for two days. At 10:01 be inappropriate for s sling with R35. Review of the point of revealed R35 did not 9:26 p.m. until after st 6/16/16, at 10:01 a.m. Review of progress merevealed the following not like either slings with she refused to use to that works with lift and 5-10 mins and insisting is uncomfortable have to talk to DON on Review of the progres 6/16/16, revealed no related to R35's conceit barriers to getting out intervention on 6/16/11. Review of R35's care interventions related to the same of the progres of t	R35 had not been out of bed a.m. DON reported it would taff to discuss cost of the force of care for transferring transfer from 6/13/16, at curveyor intervention on the cost of the force of the force of the cost of the force of the cost of the co	21805			
	director of nursing [D0 [LSW] or designee co procedure on appropries residents and treating respect. The DON an educate all staff on appresidents and treating respect. DON and LS	OD OF CORRECTION: The ON] and social worker uld develop a policy and riate interactions with residents with dignity and d LSW or designee could propriate interactions with residents with dignity and W or designee could audit not and report results to the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
		00776	B. WING		06/16/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
			VENUE SOUT			
SLEEPY E	YE CARE CENTER		YE, MN 56085	23		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	-
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	ΓE
21805	Continued From page	e 19	21805			
	facility quality assurar	nce committee.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21810	MN St. Statute 144.69 Residents of HC Fac.		21810			
	Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure call light was within reach for 1 of 1 resident (R97) dependent on staff for meeting cares.					
	reach if she needed a located hanging from floor next to R97's be was walking down the room. R97 was seate door. RN-A verified ca draped call light cord R97, and clipped it to R97 if she could push pushed red button. W	m. during resident as not observed within R97's assistance from staff. It was wall call light box onto the d. Registered nurse (RN)-A e hall and came into R97's d in wheelchair next to room all light was not within reach, over bed, brought it over to her sweater. RN-A asked a red call light and R97 //hen asked if R97 could use ated she "uses button at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00776	B. WING		06	/16/2016
	ROVIDER OR SUPPLIER	1105 3R	ADDRESS, CITY, STAT D AVENUE SOUTH Z EYE, MN 56085			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21810	times and does need it." R97's face sheet inclusions pecified sequelae generalized muscle with wheelchair, physically walker, and monitor for the control of the control o	it to be there for her to use uded diagnoses of of cerebral infarction and yeakness. d 6/6/16, activities of daily cluded physical assist of one ical assist of one with or assist with transfers. .m. director of nursing ectation was that call light ent to reach it. s call light use policy dated as sure call lights are placed at all times, never on the d." OD OF CORRECTION: The of nursing or designee cies and procedures are inplemented and monitored Il lights are within reach and	21810			
21830	Residents of HC Fac.	tion in planning treatment;	21830			
	(a) Residents shall h	nave the right to participate				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00776	B. WING		06/16/2016	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	1105 3RD A	VENUE SOUT	HWEST		
SLEEPY EYE CARE CENTER	SLEEPY E	/E, MN 56085			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
21830 Continued From page 2	21	21830			
in the planning of their includes the opportunity alternatives with individe opportunity to request a care conferences, and to family member or other both. In the event that to present, a family member chosen by the resident conferences. (b) If a resident who conferences. (b) If a resident who conferences. (b) If a resident who conferences of the facility efforts as required under either a family member writing by the resident at an emergency that the readmitted to the facility. If a family member to particular planning, unless the fact to believe the resident in directive to the contrary specified in writing that member included in treatments in the facility member to particular planning, the facility muture efforts, consistent with repractice, to determine if executed an advance directive to the contrained of the facility muture efforts, consistent with repractice, to determine if executed an advance directive to the contrained of the facility muture efforts, consistent with repractice, to determine if executed an advance directive to the contrained of the facility muture efforts, consistent with repractice, to determine if executed an advance directive to the contrained of the facility muture efforts.	health care. This right of to discuss treatment and ual caregivers, the and participate in formal the right to include a chosen representative or the resident cannot be ser or other representative may be included in such senters a facility is see or is unable to the shall make reasonable er paragraph (c) to notify or a person designated in as the person to contact in resident has been. The facility shall allow the signate in treatment shifty knows or has reason has an effective advance or knows the resident has they do not want a family atment planning. After the but prior to allowing a signate in treatment last make reasonable reasonable medical of the resident has irrective relative to the ecisions. For purposes of the lable efforts" include: resonal effects of the ladical records of the lad	21830			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06/1	6/2016
	ROVIDER OR SUPPLIER	1105 3RD A	RESS, CITY, STA VENUE SOUT (E, MN 56085			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21830	care; and (4) inquiring of the resident normally goe whether the resident I directive. If a facility is designated emergency member to participate accordance with this pliable to resident for different the notification of the emergency contact or family member was in patient's privacy rights (c) In making reason family member or designate the facility shall attemmembers or a designate examining the person and the medical record possession of the facility social service agency agency that the resident the facility has been underson the facility social service agency or location that assists a facility subdivision is not liab damages on the grouthe family member or designated emergency subdivision is not liab damages on the grouthe family member or designated emergency subdivision is not liab damages on the grouther family member or designated emergency subdivision is not liab damages on the grouther family member or designated emergency subdivision is not liab damages on the grouther family member or designated emergency and the grouther family member or designated emergency identifying and notifying and	the resident has a e resident normally goes for physician to whom the so for care, if known, has executed an advance notifies a family member or cy contact or allows a family in treatment planning in paragraph, the facility is not amages on the grounds that family member or the participation of the inproper or violated the solonable efforts to notify a signated emergency contact, put to identify family atted emergency contact by all effects of the resident reds of the resident in the sility. If the facility is unable inber or designated ithin 24 hours after the shall notify the county or local law enforcement ent has been admitted and anable to notify a family demergency contact. The agency and local law shall assist the facility in ing a family member or cy contact. A county social all law enforcement agency in implementing this	21830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D WING			
		00776	B. WING		06/1	6/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
SLEEPY E	YE CARE CENTER		VENUE SOUT (E, MN 56085	HWEST		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21830	Continued From page	23	21830			
	or violated the patient					
	by: Based on interview at facility failed to asses preferences for 1 of 1 choices (R7). Findings include: R7's minimum data so revealed R7 had seven had no behaviors related required physical help transfer only for bathi	resident reviewed for et (MDS) dated 5/2/16, ere cognitive impairment, sted to rejection of care and o from staff, limited to ng.				
	R7's family member, (F)-A was interviewed via phone on 6/14/16, at 3:24 p.m. F-A reported R7 used to shower at least three times a week at home. F-A reported she was unsure how frequently R7 was bathed at the facility. On 6/15/16, at 2:29 p.m. F-A was observed visiting with R7 in his room. F-A reported no one had asked her about how many times R7 would like to bathe each week and was unsure if staff asked R7 or another family member. F-A reported R7 was getting bathed at least 2-3 times each week while at home and would expect the facility would bathe R7 at least twice each week. R7 had trouble remembering and reporting his prior bathing schedule. On 6/15/16, at 2:33 p.m. the director of nursing (DON) reported the bathing schedule was determined by room number and residents were scheduled once a week. A resident would need to					

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AND DIAN OF CORRECTION IN IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00776	B. WING		06/1	6/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
SLEEPY E	EYE CARE CENTER		AVENUE SOUT YE, MN 56085			
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	each week. At 3:08 p. no system to assess a of bathing times resid There was no docume preferences of R7. On 6/15/16, at 3:16 p. (LSW)-A reported the system related to assepreferences. Review of the bath air revealed R7 was schebathing once each we care bathing informati revealed R7 was bath 6/5 and 6/12. SUGGESTED METHORIZED METHORIZED METHORIZED CONTROLLED IN CARRELLED IN CA	was getting bathed once m. DON reported there was and document the number ents wanted each week. entation about the bathing .m. the social worker, re was no documentation or essing resident bathing de schedule, undated, eduled to be assisted with eek. Review of the point of ion from 5/1/16, to 6/15/16, led on 5/1, 5/10, 5/15, 5/29,	21830			

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