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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PUED

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00776

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245225**

2.STATE VENDOR OR MEDICAID NO.
(L2) **685740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SLEEPY EYE CARE CENTER**
(L4) **1105 3RD AVENUE SOUTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/16/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Cynthia Wentkiewicz, HFE NE II — 07/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/29/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to 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. Findings include: Review of the minimum data set (MDS) dated 5/7/16, revealed R35 was cognitively intact, had no delusions or hallucinations, behaviors related	F 241	It is the practice of the Sleepy Eye Care Center to promote care for residents in a manner and in an environment that promotes maintenance or enhancement of each resident□s quality of life. Resident #35 Social Services will provide support to resident twice a week for emotional well being as resident refuses to see in house psychologist. All staff will be educated on resident	7/26/16

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

Electronically Signed | 07/08/2016

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F 241	Continued From page 1 to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it difficult to use other slings in the facility. R35 reported the staff had tried to transfer her with another lift and sling and it almost tipped. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported she felt guilty and like she had done something wrong that required the facility to spend so much money on a sling for her. R35 reported she told staff she hoped they got a refund on the sling and they told her they did not know and had to get corporate approval for the sling because it was $700. R35 added she could	F 241	rights, focusing on the right to dignity by July 26th, 2016. Relias Learning training was set up to educate all staff on resident rights. The Director of Nursing is responsible for overall compliance. The facility alleges that will be in substantial compliance and complete all action items by July 26th, 2016.	

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F 241	Continued From page 2	F 241		

not get out of bed today to spend time with a family member who visited earlier in the day. R35 reported the nursing assistants had come in and saw she was emotional in the last few days. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. At 1:58 p.m. R35 reported a nursing staff member and a business staff member had told her the cost of the new sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.)

On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A explained the facility had purchased one for her that cost $700 and R35 complained that it was too big and would not fit in R35's wheelchair. LPN-A reported she did not tell the director of nursing (DON) about R35's concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. LPN-A reported she told R35 "my hands are tied, this is what I have." LPN-A reported she told R35 the sling was expensive, but did not tell R35 the cost. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON and LPN-A reported R35 had not been out of bed for two days. At 10:01 a.m. DON reported it would be inappropriate for staff to discuss cost of the

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F 241	Continued From page 3 sling with R35. 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. Review of R35's care plan revealed no interventions related to R35's concerns regarding her sling until 6/16/16, after surveyor intervention.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by:	F 242		7/26/16

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F 242	Continued From page 4 Based on interview and document review, the facility failed to assess bathing frequency preferences for 1 of 1 resident reviewed for choices (R7). Findings include: R7's minimum data set (MDS) dated 5/2/16, revealed R7 had severe cognitive impairment, had no behaviors related to rejection of care and required physical help from staff, limited to transfer only for bathing. 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 request if they wanted to be bathed more than once each week. R7 was getting bathed once each week. At 3:08 p.m. DON reported there was no system to assess and document the number of bathing times residents wanted each week. There was no documentation about the bathing	F 242	It is the practice of the Sleepy Eye Care Center to ensure residents have the right to make choices about aspects of his or her life in the facility that are significant to the resident. Policy and nursing assessments were reviewed. Admission nursing assessment was revised to include the resident□s preference of type of bath, time of bath, and frequency of bath with family and resident on admission. Bathing preferences will be reviewed quarterly at care conferences or as needed and adjustments will be made to the care plan to accommodate the resident□s preferences. Resident #7 Resident was interviewed regarding preference on the type of bath, time of bath, and frequency of bath. Care plan was reviewed and updated. All current residents will be reviewed on the care conference schedule and care plans will be updated as needed. Nursing staff will be educated on revised admission assessment and new practice of including the resident□s preference of type of bath, time of bath, and frequency of bath with family and resident on admission and reviewed quarterly at care conferences by July 26th, 2016. The Director of Nursing is responsible for overall compliance.	

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F 242	Continued From page 5 preferences of R7. On 6/15/16, at 3:16 p.m. the social worker, (LSW)-A reported there was no documentation or system related to assessing resident bathing preferences. Review of the bath aide schedule, undated, revealed R7 was scheduled to be assisted with bathing once each week. Review of the point of care bathing information from 5/1/16, to 6/15/16, revealed R7 was bathed on 5/1, 5/10, 5/15, 5/29, 6/5 and 6/12.	F 242	The facility alleges that will be in substantial compliance and complete all action items by July 26th, 2016.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This 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. On 6/15/16, at 8:43 a.m. during resident interview, call light was not observed within R97's reach if she needed assistance from staff. It was located hanging from wall call light box onto the floor next to R97's bed. Registered nurse (RN)-A was walking down the hall and came into R97's	F 246	It is the practice of the Sleepy Eye Care Center to ensure a resident has the right to reside and receive services in the facility with reasonable accommodations 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 importance of residents having call light within reach and	7/26/16

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F 246	Continued From page 6 room. R97 was seated in wheelchair next to room door. RN-A verified call light was not within reach, draped call light cord over bed, brought it over to R97, and clipped it to her sweater. RN-A asked R97 if she could push red call light and R97 pushed red button. When asked if R97 could use the call light, RN-A stated she "uses button at times and does need it to be there for her to use it." R97's face sheet included diagnoses of unspecified sequelae of cerebral infarction and generalized muscle weakness. 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. On 6/15/16, at 3:27 p.m. director of nursing (DON) stated her expectation was that call light was in place for resident to reach it. Review of the facility's call light use policy dated 2006, indicated "11. Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand."	F 246	on resident□s rights by July 26th, 2016. A random audit will be performed weekly by the Interdisciplinary Team to ensure call lights are within reach of all residents. The Director of Nursing is responsible for overall compliance along with communicating results of audits to QA meeting. The facility alleges that it will be in substantial compliance by July 26th, 2016.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		7/26/16

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F 280	Continued From page 7 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 3 resident (R66) reviewed for skin conditions and 1 of 1 residents (R35) reviewed for a change in transfer equipment, which caused her concern and discomfort. Findings include: R35's minimum data set (MDS), dated 5/7/16, revealed R35 was cognitively intact, had no delusions or hallucinations, behaviors related to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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	F 280	It is the practice of the Sleepy Eye Care Center to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team as determined by the resident□s needs, and the participation of the resident and family , and to periodically review and revise the care plan after each assessment. Resident #35 Care plan has been reviewed and revised 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 revised to include type of skin alteration and interventions for skin alteration. Staff will be educated by July 26th, 2016 to ensure plan of care reflects current skin	

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F 280	Continued From page 8 6/14/16, and 6/15/16. R35 was asked if staff were providing assistance to her transfer out of bed. R35 explained the nursing staff had spoken to her in April and told her the slings were not a right fit and R35 would need a new sling. Approximately one week ago, the facility received the new sling for her to use. R35 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it difficult to use other slings in the facility. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.) On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A reported she did not tell the director of nursing (DON) about R35's concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON and LPN-A reported R35 had not been out of bed for two days. DON was	F 280	condition status of each resident. A random audit will be performed by the Interdisciplinary Team weekly on 10% of residents to ensure specific skin alterations and interventions are included in the plan of care. The Director of Nursing is responsible for compliance along with communicating results of audits to QA meeting. The facility alleges that it will be in substantial compliance and complete all action items by July 26th, 2016.	

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asked if the care plan had been updated since R35 had trouble adjusting to the use of the new sling and was spending more time in bed. DON responded she would have to check the care plan and did not know.

On 6/16/16, at 9:56 a.m. NA-B reported she had assisted R35 out of bed on Saturday and Sunday. NA-B reported R35 was upset with the sling and reported it did not fit in the wheelchair and was too thick. NA-B reported transferring from bed to recliner was difficult for R35 and R35 was upset. 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.

Review of R35's care plan revealed no interventions related to R35's concerns regarding

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her sling until 6/16/16. On 6/16/16, the care plan was modified and read "Resident has been refusing new sling, stating it is uncomfortable. Continue to work with resident." The care plan was also revised on 6/16/16, to read "Transfers-requires physical assist of two and (specialized) hoyer lift for transfers." These tasks were assigned to nursing assistants. There was no guidance on how nursing assistants were to "work with resident". The care plan was also revised on 6/16/16, to note "Encourage resident to get up daily and reposition/offload. Resident prefers to stay in bed-Refuses." There was no guidance on handling R35's refusal to get out of bed or to review risks and benefits of this refusal. There were no interventions to get her out of bed despite concerns related to sling, such as approach to use or methods to make her more comfortable. There were no interventions to mitigate the potential impact of not getting out of bed because of concerns related to sling, such as skin, comfort, mobility, social and emotional issues.

R66's care plan lacked current skin tear on right forearm and indicated that R66 had pressure area on the left outer heel.
Care Plan with revision date 3/24/16, read, "Focus: Resident has a pressure area on left outer heel. Has the following risk factors: incontinent of urine, Alzheimer's Dementia, DM, appetite varies.--update res. has unstageable pressure ulcer on left great toe. Goal: The Skin will remain intact. Interventions: Requires assistance with repositioning every 2 hrs (hours) while sitting and requires assistance with turning and repositioning every 4 hrs (hour) while lying. Res. (resident) does refuse to be turned at noc (overnight) at times. Inspect skin daily with cares

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and Nursing Assistant to report any concerns to the Nurse. Keep resident's bed linen dry & wrinkle free. Alternating air mattress for bed. Pressure reducing device for chair. Weekly skin assessment by Licensed Nurses." However the care plan lacked current skin tear on right forearm.

R66's admission record with diagnosis which included Alzheimer's disease, Dementia, Delusional, Hallucinations, restlessness and agitation.

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

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F 280	Continued From page 12 change or new skin concerns such as skin tears. 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."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents reviewed with a recent change in transfer equipment (R35) was provided with appropriate care and services to successfully meet her physical, social and psychosocial needs and preferences to spend time out of bed. Findings include: Review of the minimum data set (MDS), dated 5/7/16, revealed R35 was cognitively intact, had	F 309	It is the practice of the Sleepy Eye Care Center to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #35 Reviewed resident□s care plan and updated transfer lift assessment. A	7/26/16

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F 309	Continued From page 13 no delusions or hallucinations, behaviors related to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it difficult to use other slings in the facility. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported she felt guilty and like she had done something wrong that required the facility to spend so much money on a sling for her. R35 reported she told staff she hoped they got a refund on the sling and they told her they did not know and had to get corporate approval for the sling because it was $700. R35 reported she was unable to bathe the day prior as scheduled. R35	F 309	custom sling is being made for resident. All residents□ care plans will be reviewed and updated to reflect current plan of care. A routine audit will be performed by the Interdisciplinary Team weekly on 10% of residents to ensure plan of care reflects current changes in residents. All nursing staff will be educated by July 26th, 2016 on monitoring residents for changes and concerns and communicating those changes to appropriate staff. The Director of Nursing is responsible for compliance along with communicating results of audits to QA meeting. The facility alleges that it will be in substantial compliance and complete all action items by July 26th, 2016.	

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added she could not get out of bed today to spend time with a family member who visited earlier in the day. R35 reported the nursing assistants had come in and saw she was emotional in the last few days. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.)

On 6/15/16, at 4:15 p.m. NA-C and NA-D reported they had just arrived for the evening shift. They reported R35 only got of of bed for special events. NA-C reported she did not offer R35 assistance out of bed during the evening shift on 6/14/16, because R35 was "emotional".

On 6/16/16, at 8:25 a.m. surveyor observed an approximately two centimeters long slit on R35's upper coccyx.

On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A explained the facility had purchased one for her that cost $700 and R35 complained that it was too big and would not fit in her wheelchair. LPN-A reported she did not tell the director of nursing (DON) about R35's concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. LPN-A reported she told

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R35 "my hands are tied, this is what I have." LPN-A reported she told R35 the sling was expensive, but did not tell R35 the cost. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON reported the open area on R35's coccyx was discovered the day prior, on 6/15/16. DON and LPN-A reported R35 had not been out of bed for two days. DON and LPN-A did not believe R35's lying in bed all day impacted the development of the open area on the coccyx. DON was asked if the care plan had been updated since R35 had trouble adjusting to the use of the new sling and was spending more time in bed. DON responded she would have to check the care plan and did not know. At 10:01 a.m. DON reported it would be inappropriate for staff to discuss cost of the sling with R35.

On 6/16/16, at 9:56 a.m. NA-B reported she had assisted R35 out of bed on Saturday and Sunday. NA-B reported R35 was upset with the sling and reported it did not fit in the wheelchair and was too thick. NA-B reported transferring from bed to recliner was difficult for R35 and R35 was upset. NA-B reported she told the DON on Monday, 6/13/16, that R35 had trouble with the new sling.

On 6/16/16, at 10:01 a.m. NA-A, NA-B and DON assisted R35 to transfer from her bed to recliner. R35 readily agreed to have DON assess the transfer. All three staff helped position R35 in her recliner. R35 reported it was uncomfortable to sit on the sling in the recliner because it was puffing up. DON tucked the sling between the arms and seats of the chair. R35 reported it was comfortable enough for the time being. At 10:27 a.m. R35 told DON and surveyor the new sling

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was a little hot, awkward and the nursing assistants had adjusted the sling earlier as it was tickling her hair. R35 reported she did not know if it was just because she would have to get adjusted to the new sling. At 12:01 a.m. R35 was still sitting in her recliner and felt the sling was still a little hot and awkward. The dietary manager, passing trays at the time, turned on the room air conditioner. At 1:58 p.m. R35 said she was still uncomfortable because there were boards in the sling. R35 was still sitting up in her recliner.

Review of R35's current orders revealed a prescriber order, dated 2/3/16,"Up daily for 2-3 hours every day and evening shift." There were no orders directing R35 to remain in bed.

Review of the point of care from May 16th until June 16th revealed R35 transferred at least once each day, until 6/10/16. R35 transferred with staff assistance between 1-3 times each day on 5/16/16 through 5/22/16; between 2-4 times each day on 5/23/16 through 5/29/16; between 2-6 times per day on 5/30/16 through 6/5/16; between 0-6 times per day on 6/6/16 through 6/12/16 (no transfers on 6/10/16) and 0 -2 times per day between 6/13/16 and 6/16/16 (no transfers from 6/13/16 at 9:26 p.m. until after surveyor intervention on 6/16/16 at 10:01 a.m.)

Review of R35's care plan revealed no interventions related to R35's concerns regarding her sling until 6/16/16, after surveyor intervention. On 6/16/16, the care plan was modified and read "Resident has been refusing new sling, stating it is uncomfortable. Continue to work with resident." The care plan was also revised on 6/16/16 to read "Transfers-requires physical assist of two and (specialized) hoyer lift for transfers." These

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17	F 309		

tasks were assigned to nursing assistants. There was no guidance on how nursing assistants were to "work with resident". The care plan was also revised on 6/16/16, to note "Encourage resident to get up daily and reposition/offload. Resident prefers to stay in bed-Refuses." There was no guidance on handling R35's refusal to get out of bed or to review risks and benefits of this refusal. There were no interventions to get her out of bed despite concerns related to sling, such as approach to use or methods to make her more comfortable. There were no interventions to mitigate the potential impact of not getting out of bed because of concerns related to sling, such as skin, comfort, mobility, social and emotional issues.

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.

Progress note, dated 6/15/15, revealed "coccyx-Pressure: Length=2.0, Width= 0.1, Depth=0, Stage II Open Slit-superficial." The prior skin assessment, dated 6/7/16, revealed no skin concerns. A progress note from 6/20/16, was scanned and emailed to survey team following the survey. The note revealed "Area on crease of upper coccyx assessed. Area is closed at this

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F 309	Continued From page 18 time. Area determined to be caused by incontinence, not pressure."	F 309		

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	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**06/14/2016**

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K 000	INITIAL COMMENTS 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	K 000	EPOC	

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.

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	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**06/14/2016**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Sleepy Eye Care Center is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(000) construction. In 1985, addition was constructed and was determined to be of Type II(000) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**06/14/2016**

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on June 14, 2016, between the hours of 10:30 AM and 1:30 PM, observation revealed penetrations above the lay-in ceiling around wires at the Hall #1 and Hall #3 smoke barrier wall. This deficient practice was verfied by the Maintenance Supervisor.	K 025	The Environmental Service Director inspected the inner and outer walls above the lay in ceiling in all hallways, including Hall #1 and Hall #3 as identified in the survey deficiency report. All penetrations that were not in compliance were sealed with fire-rated caulk.	6/21/16
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by:	K 054		6/30/16

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K 054	Continued From page 3 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 FINDINGS INCLUDE: On 6/14/2016 between 10:30 AM and 1:30 PM, during a review of available records provided by facility staff, it was revealed that the smoke detector sensitivity test had not been conducted since 06-10-2013. This deficient practice was verfied by the Maintenance Supervisor.	K 054	Viking Automatic Sprinkler Company was at facility on 06-24-2016 to perform the required smoke detector sensitivity test. All smoke detectors were inspected and tested to ensure compliance with manufacturing specifications. Protection systems was at facility on 06-30-2016. Testing of the system was completed and within compliance.	

MDH
Minnesota
Department
of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00776	A. BUILDING: _____ B. WING _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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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 your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 23rd, 24th, 25th and 26th 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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2 000	Continued From page 3 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. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 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 your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of	2 570		7/26/16

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2 570	Continued From page 4 the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 3 residents (R66) reviewed for skin conditions and 1 of 1 residents (R35) reviewed for a change in transfer equipment, which caused her concern and discomfort. Findings include: R35's minimum data set (MDS), dated 5/7/16, revealed R35 was cognitively intact, had no delusions or hallucinations, behaviors related to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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 explained the nursing staff had spoken to her in April and told her the slings were not a right fit and R35 would need a new sling. Approximately one week ago, the facility received the new sling for her to use. R35 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it	2 570	Corrected	

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2 570	Continued From page 5 difficult to use other slings in the facility. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.) On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A reported she did not tell the director of nursing (DON) about R35's concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON and LPN-A reported R35 had not been out of bed for two days. DON was asked if the care plan had been updated since R35 had trouble adjusting to the use of the new sling and was spending more time in bed. DON responded she would have to check the care plan and did not know. On 6/16/16, at 9:56 a.m. NA-B reported she had assisted R35 out of bed on Saturday and Sunday. NA-B reported R35 was upset with the sling and reported it did not fit in the wheelchair and was too thick. NA-B reported transferring from bed to recliner was difficult for R35 and R35 was upset.	2 570		

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	00776	A. BUILDING: _____ B. WING _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 570	Continued From page 6 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. Review of R35's care plan revealed no interventions related to R35's concerns regarding her sling until 6/16/16. On 6/16/16, the care plan was modified and read "Resident has been refusing new sling, stating it is uncomfortable. Continue to work with resident." The care plan was also revised on 6/16/16, to read "Transfers-requires physical assist of two and (specialized) hoyer lift for transfers." These tasks were assigned to nursing assistants. There was no guidance on how nursing assistants were to "work with resident". The care plan was also revised on 6/16/16, to note "Encourage resident to get up daily and reposition/offload. Resident prefers to stay in bed-Refuses." There was no	2 570		

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2 570	Continued From page 7 guidance on handling R35's refusal to get out of bed or to review risks and benefits of this refusal. There were no interventions to get her out of bed despite concerns related to sling, such as approach to use or methods to make her more comfortable. There were no interventions to mitigate the potential impact of not getting out of bed because of concerns related to sling, such as skin, comfort, mobility, social and emotional issues. R66's care plan lacked current skin tear on right forearm and indicated that R66 had pressure area on the left outer heel. Care Plan with revision date 3/24/16, read, "Focus: Resident has a pressure area on left outer heel. Has the following risk factors: incontinent of urine, Alzheimer's Dementia, DM, appetite varies.--update res. has unstageable pressure ulcer on left great toe. Goal: The Skin will remain intact. Interventions: Requires assistance with repositioning every 2 hrs (hours) while sitting and requires assistance with turning and repositioning every 4 hrs (hour) while lying. Res. (resident) does refuse to be turned at noc (overnight) at times. Inspect skin daily with cares and Nursing Assistant to report any concerns to the Nurse. Keep resident's bed linen dry & wrinkle free. Alternating air mattress for bed. Pressure reducing device for chair. Weekly skin assessment by Licensed Nurses." However the care plan lacked current skin tear on right forearm. R66's admission record with diagnosis which included Alzheimer's disease, Dementia, Delusional, Hallucinations, restlessness and agitation.	2 570		

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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. 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		

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2 570	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents reviewed with a recent change in transfer equipment (R35) was provided with appropriate care and services to successfully meet her physical, social and psychosocial needs and preferences to spend time out of bed.	2 830	Corrected	7/26/16

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2 830	Continued From page 10 Findings include: Review of the minimum data set (MDS), dated 5/7/16, revealed R35 was cognitively intact, had no delusions or hallucinations, behaviors related to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it difficult to use other slings in the facility. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported she felt guilty and like she had done something wrong that required the facility to spend so much money on a sling for her. R35 reported she told staff she hoped they got a	2 830		

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2 830	Continued From page 11	2 830		

refund on the sling and they told her they did not know and had to get corporate approval for the sling because it was $700. R35 reported she was unable to bathe the day prior as scheduled. R35 added she could not get out of bed today to spend time with a family member who visited earlier in the day. R35 reported the nursing assistants had come in and saw she was emotional in the last few days. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.)

On 6/15/16, at 4:15 p.m. NA-C and NA-D reported they had just arrived for the evening shift. They reported R35 only got of of bed for special events. NA-C reported she did not offer R35 assistance out of bed during the evening shift on 6/14/16, because R35 was "emotional".

On 6/16/16, at 8:25 a.m. surveyor observed an approximately two centimeters long slit on R35's upper coccyx.

On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A explained the facility had purchased one for her that cost $700 and R35 complained that it was too big and would not fit in her wheelchair. LPN-A reported she did not tell the director of nursing (DON) about R35's

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2 830	Continued From page 12	2 830		

concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. LPN-A reported she told R35 "my hands are tied, this is what I have." LPN-A reported she told R35 the sling was expensive, but did not tell R35 the cost. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON reported the open area on R35's coccyx was discovered the day prior, on 6/15/16. DON and LPN-A reported R35 had not been out of bed for two days. DON and LPN-A did not believe R35's lying in bed all day impacted the development of the open area on the coccyx. DON was asked if the care plan had been updated since R35 had trouble adjusting to the use of the new sling and was spending more time in bed. DON responded she would have to check the care plan and did not know. At 10:01 a.m. DON reported it would be inappropriate for staff to discuss cost of the sling with R35.

On 6/16/16, at 9:56 a.m. NA-B reported she had assisted R35 out of bed on Saturday and Sunday. NA-B reported R35 was upset with the sling and reported it did not fit in the wheelchair and was too thick. NA-B reported transferring from bed to recliner was difficult for R35 and R35 was upset. NA-B reported she told the DON on Monday, 6/13/16, that R35 had trouble with the new sling.

On 6/16/16, at 10:01 a.m. NA-A, NA-B and DON assisted R35 to transfer from her bed to recliner. R35 readily agreed to have DON assess the transfer. All three staff helped position R35 in her recliner. R35 reported it was uncomfortable to sit on the sling in the recliner because it was puffing up. DON tucked the sling between the arms and seats of the chair. R35 reported it was

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2 830	Continued From page 13	2 830		

comfortable enough for the time being. At 10:27 a.m. R35 told DON and surveyor the new sling was a little hot, awkward and the nursing assistants had adjusted the sling earlier as it was tickling her hair. R35 reported she did not know if it was just because she would have to get adjusted to the new sling. At 12:01 a.m. R35 was still sitting in her recliner and felt the sling was still a little hot and awkward. The dietary manager, passing trays at the time, turned on the room air conditioner. At 1:58 p.m. R35 said she was still uncomfortable because there were boards in the sling. R35 was still sitting up in her recliner.

Review of R35's current orders revealed a prescriber order, dated 2/3/16,"Up daily for 2-3 hours every day and evening shift." There were no orders directing R35 to remain in bed.

Review of the point of care from May 16th until June 16th revealed R35 transferred at least once each day, until 6/10/16. R35 transferred with staff assistance between 1-3 times each day on 5/16/16 through 5/22/16; between 2-4 times each day on 5/23/16 through 5/29/16; between 2-6 times per day on 5/30/16 through 6/5/16; between 0-6 times per day on 6/6/16 through 6/12/16 (no transfers on 6/10/16) and 0 -2 times per day between 6/13/16 and 6/16/16 (no transfers from 6/13/16 at 9:26 p.m. until after surveyor intervention on 6/16/16 at 10:01 a.m.)

Review of R35's care plan revealed no interventions related to R35's concerns regarding her sling until 6/16/16, after surveyor intervention. On 6/16/16, the care plan was modified and read "Resident has been refusing new sling, stating it is uncomfortable. Continue to work with resident." The care plan was also revised on 6/16/16 to read "Transfers-requires physical assist of two

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2 830	Continued From page 14	2 830		

and (specialized) hoyer lift for transfers." These tasks were assigned to nursing assistants. There was no guidance on how nursing assistants were to "work with resident". The care plan was also revised on 6/16/16, to note "Encourage resident to get up daily and reposition/offload. Resident prefers to stay in bed-Refuses." There was no guidance on handling R35's refusal to get out of bed or to review risks and benefits of this refusal. There were no interventions to get her out of bed despite concerns related to sling, such as approach to use or methods to make her more comfortable. There were no interventions to mitigate the potential impact of not getting out of bed because of concerns related to sling, such as skin, comfort, mobility, social and emotional issues.

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.

Progress note, dated 6/15/15, revealed "coccyx-Pressure: Length=2.0, Width= 0.1, Depth=0, Stage II Open Slit-superficial." The prior skin assessment, dated 6/7/16, revealed no skin concerns. A progress note from 6/20/16, was scanned and emailed to survey team following the survey. The note revealed "Area on crease of upper coccyx assessed. Area is closed at this

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2 830	Continued From page 15 time. Area determined to be caused by incontinence, not pressure." SUGGESTED METHOD OF CORRECTION: The director of nursing [DON] and social worker [LSW] or designee could review, revise and/or develop a procedure for monitoring residents for changes and concerns, communicating changes and concerns to the appropriate staff and following up on changes and concerns. DON and LSW or designee could educate all staff on this procedure. DON and LSW or designee could audit for continued compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
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	Corrected	7/26/16

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21805	Continued From page 16 Findings include: Review of the minimum data set (MDS) dated 5/7/16, revealed R35 was cognitively intact, had no delusions or hallucinations, behaviors related to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it difficult to use other slings in the facility. R35 reported the staff had tried to transfer her with another lift and sling and it almost tipped. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported she felt guilty and like she had done something wrong that required the facility to spend so much money on a sling for her. R35	21805		

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reported she told staff she hoped they got a refund on the sling and they told her they did not know and had to get corporate approval for the sling because it was $700. R35 added she could not get out of bed today to spend time with a family member who visited earlier in the day. R35 reported the nursing assistants had come in and saw she was emotional in the last few days. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. At 1:58 p.m. R35 reported a nursing staff member and a business staff member had told her the cost of the new sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.)

On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A explained the facility had purchased one for her that cost $700 and R35 complained that it was too big and would not fit in R35's wheelchair. LPN-A reported she did not tell the director of nursing (DON) about R35's concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. LPN-A reported she told R35 "my hands are tied, this is what I have." LPN-A reported she told R35 the sling was expensive, but did not tell R35 the cost. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON

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	00776	A. BUILDING: _____ B. WING _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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and LPN-A reported R35 had not been out of bed for two days. At 10:01 a.m. DON reported it would be inappropriate for staff to discuss cost of the sling with R35.

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.

Review of R35's care plan revealed no interventions related to R35's concerns regarding her sling until 6/16/16, after surveyor intervention.

SUGGESTED METHOD OF CORRECTION: The director of nursing [DON] and social worker [LSW] or designee could develop a policy and procedure on appropriate interactions with residents and treating residents with dignity and respect. The DON and LSW or designee could educate all staff on appropriate interactions with residents and treating residents with dignity and respect. DON and LSW or designee could audit for continued compliance and report results to the

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21805	Continued From page 19 facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights 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. On 6/15/16, at 8:43 a.m. during resident interview, call light was not observed within R97's reach if she needed assistance from staff. It was located hanging from wall call light box onto the floor next to R97's bed. Registered nurse (RN)-A was walking down the hall and came into R97's room. R97 was seated in wheelchair next to room door. RN-A verified call light was not within reach, draped call light cord over bed, brought it over to R97, and clipped it to her sweater. RN-A asked R97 if she could push red call light and R97 pushed red button. When asked if R97 could use the call light, RN-A stated she "uses button at	21810	Corrected	7/26/16

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21810	Continued From page 20 times and does need it to be there for her to use it." R97's face sheet included diagnoses of unspecified sequelae of cerebral infarction and generalized muscle weakness. 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. On 6/15/16, at 3:27 p.m. director of nursing (DON) stated her expectation was that call light was in place for resident to reach it. Review of the facility's call light use policy dated 2006, indicated "11. Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could assure that policies and procedures are revised, up to date, implemented and monitored to assure resident call lights are within reach and that residents needs are met. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21810		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate	21830		7/26/16

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in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance

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directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper

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21830	Continued From page 23 or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess bathing frequency preferences for 1 of 1 resident reviewed for choices (R7). Findings include: R7's minimum data set (MDS) dated 5/2/16, revealed R7 had severe cognitive impairment, had no behaviors related to rejection of care and required physical help from staff, limited to transfer only for bathing. 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 request if they wanted to be bathed more than	21830	Corrected	

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21830	Continued From page 24 once each week. R7 was getting bathed once each week. At 3:08 p.m. DON reported there was no system to assess and document the number of bathing times residents wanted each week. There was no documentation about the bathing preferences of R7. On 6/15/16, at 3:16 p.m. the social worker, (LSW)-A reported there was no documentation or system related to assessing resident bathing preferences. Review of the bath aide schedule, undated, revealed R7 was scheduled to be assisted with bathing once each week. Review of the point of care bathing information from 5/1/16, to 6/15/16, revealed R7 was bathed on 5/1, 5/10, 5/15, 5/29, 6/5 and 6/12. SUGGESTED METHOD OF CORRECTION: The director of nursing [DON] and social worker [LSW] or designee could develop a procedure to ensure resident daily schedule preferences, including bathing preferences, are assessed, care planned and implemented. DON and SW or designee could educate all staff about honoring resident choices. DON and LSW or designee could audit for continued compliance and report results to the facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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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 your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 23rd, 24th, 25th and 26th 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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2 000	Continued From page 3 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. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 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 your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of	2 570		

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2 570	Continued From page 4 the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 3 residents (R66) reviewed for skin conditions and 1 of 1 residents (R35) reviewed for a change in transfer equipment, which caused her concern and discomfort. Findings include: R35's minimum data set (MDS), dated 5/7/16, revealed R35 was cognitively intact, had no delusions or hallucinations, behaviors related to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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 explained the nursing staff had spoken to her in April and told her the slings were not a right fit and R35 would need a new sling. Approximately one week ago, the facility received the new sling for her to use. R35 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it	2 570		

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2 570	Continued From page 5 difficult to use other slings in the facility. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.) On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A reported she did not tell the director of nursing (DON) about R35's concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON and LPN-A reported R35 had not been out of bed for two days. DON was asked if the care plan had been updated since R35 had trouble adjusting to the use of the new sling and was spending more time in bed. DON responded she would have to check the care plan and did not know. On 6/16/16, at 9:56 a.m. NA-B reported she had assisted R35 out of bed on Saturday and Sunday. NA-B reported R35 was upset with the sling and reported it did not fit in the wheelchair and was too thick. NA-B reported transferring from bed to recliner was difficult for R35 and R35 was upset.	2 570		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 6 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. Review of R35's care plan revealed no interventions related to R35's concerns regarding her sling until 6/16/16. On 6/16/16, the care plan was modified and read "Resident has been refusing new sling, stating it is uncomfortable. Continue to work with resident." The care plan was also revised on 6/16/16, to read "Transfers-requires physical assist of two and (specialized) hoyer lift for transfers." These tasks were assigned to nursing assistants. There was no guidance on how nursing assistants were to "work with resident". The care plan was also revised on 6/16/16, to note "Encourage resident to get up daily and reposition/offload. Resident prefers to stay in bed-Refuses." There was no	2 570		

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	00776	A. BUILDING: _____ B. WING _____	06/16/2016

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2 570	Continued From page 7 guidance on handling R35's refusal to get out of bed or to review risks and benefits of this refusal. There were no interventions to get her out of bed despite concerns related to sling, such as approach to use or methods to make her more comfortable. There were no interventions to mitigate the potential impact of not getting out of bed because of concerns related to sling, such as skin, comfort, mobility, social and emotional issues. R66's care plan lacked current skin tear on right forearm and indicated that R66 had pressure area on the left outer heel. Care Plan with revision date 3/24/16, read, "Focus: Resident has a pressure area on left outer heel. Has the following risk factors: incontinent of urine, Alzheimer's Dementia, DM, appetite varies.--update res. has unstageable pressure ulcer on left great toe. Goal: The Skin will remain intact. Interventions: Requires assistance with repositioning every 2 hrs (hours) while sitting and requires assistance with turning and repositioning every 4 hrs (hour) while lying. Res. (resident) does refuse to be turned at noc (overnight) at times. Inspect skin daily with cares and Nursing Assistant to report any concerns to the Nurse. Keep resident's bed linen dry & wrinkle free. Alternating air mattress for bed. Pressure reducing device for chair. Weekly skin assessment by Licensed Nurses." However the care plan lacked current skin tear on right forearm. R66's admission record with diagnosis which included Alzheimer's disease, Dementia, Delusional, Hallucinations, restlessness and agitation.	2 570		

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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. 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		

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2 570	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents reviewed with a recent change in transfer equipment (R35) was provided with appropriate care and services to successfully meet her physical, social and psychosocial needs and preferences to spend time out of bed.	2 830		

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2 830	Continued From page 10 Findings include: Review of the minimum data set (MDS), dated 5/7/16, revealed R35 was cognitively intact, had no delusions or hallucinations, behaviors related to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it difficult to use other slings in the facility. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported she felt guilty and like she had done something wrong that required the facility to spend so much money on a sling for her. R35 reported she told staff she hoped they got a	2 830		

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2 830	Continued From page 11	2 830		

refund on the sling and they told her they did not know and had to get corporate approval for the sling because it was $700. R35 reported she was unable to bathe the day prior as scheduled. R35 added she could not get out of bed today to spend time with a family member who visited earlier in the day. R35 reported the nursing assistants had come in and saw she was emotional in the last few days. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.)

On 6/15/16, at 4:15 p.m. NA-C and NA-D reported they had just arrived for the evening shift. They reported R35 only got of of bed for special events. NA-C reported she did not offer R35 assistance out of bed during the evening shift on 6/14/16, because R35 was "emotional".

On 6/16/16, at 8:25 a.m. surveyor observed an approximately two centimeters long slit on R35's upper coccyx.

On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A explained the facility had purchased one for her that cost $700 and R35 complained that it was too big and would not fit in her wheelchair. LPN-A reported she did not tell the director of nursing (DON) about R35's

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2 830	Continued From page 12	2 830		

concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. LPN-A reported she told R35 "my hands are tied, this is what I have." LPN-A reported she told R35 the sling was expensive, but did not tell R35 the cost. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON reported the open area on R35's coccyx was discovered the day prior, on 6/15/16. DON and LPN-A reported R35 had not been out of bed for two days. DON and LPN-A did not believe R35's lying in bed all day impacted the development of the open area on the coccyx. DON was asked if the care plan had been updated since R35 had trouble adjusting to the use of the new sling and was spending more time in bed. DON responded she would have to check the care plan and did not know. At 10:01 a.m. DON reported it would be inappropriate for staff to discuss cost of the sling with R35.

On 6/16/16, at 9:56 a.m. NA-B reported she had assisted R35 out of bed on Saturday and Sunday. NA-B reported R35 was upset with the sling and reported it did not fit in the wheelchair and was too thick. NA-B reported transferring from bed to recliner was difficult for R35 and R35 was upset. NA-B reported she told the DON on Monday, 6/13/16, that R35 had trouble with the new sling.

On 6/16/16, at 10:01 a.m. NA-A, NA-B and DON assisted R35 to transfer from her bed to recliner. R35 readily agreed to have DON assess the transfer. All three staff helped position R35 in her recliner. R35 reported it was uncomfortable to sit on the sling in the recliner because it was puffing up. DON tucked the sling between the arms and seats of the chair. R35 reported it was

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2 830	Continued From page 13	2 830		

comfortable enough for the time being. At 10:27 a.m. R35 told DON and surveyor the new sling was a little hot, awkward and the nursing assistants had adjusted the sling earlier as it was tickling her hair. R35 reported she did not know if it was just because she would have to get adjusted to the new sling. At 12:01 a.m. R35 was still sitting in her recliner and felt the sling was still a little hot and awkward. The dietary manager, passing trays at the time, turned on the room air conditioner. At 1:58 p.m. R35 said she was still uncomfortable because there were boards in the sling. R35 was still sitting up in her recliner.

Review of R35's current orders revealed a prescriber order, dated 2/3/16,"Up daily for 2-3 hours every day and evening shift." There were no orders directing R35 to remain in bed.

Review of the point of care from May 16th until June 16th revealed R35 transferred at least once each day, until 6/10/16. R35 transferred with staff assistance between 1-3 times each day on 5/16/16 through 5/22/16; between 2-4 times each day on 5/23/16 through 5/29/16; between 2-6 times per day on 5/30/16 through 6/5/16; between 0-6 times per day on 6/6/16 through 6/12/16 (no transfers on 6/10/16) and 0 -2 times per day between 6/13/16 and 6/16/16 (no transfers from 6/13/16 at 9:26 p.m. until after surveyor intervention on 6/16/16 at 10:01 a.m.)

Review of R35's care plan revealed no interventions related to R35's concerns regarding her sling until 6/16/16, after surveyor intervention. On 6/16/16, the care plan was modified and read "Resident has been refusing new sling, stating it is uncomfortable. Continue to work with resident." The care plan was also revised on 6/16/16 to read "Transfers-requires physical assist of two

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2 830	Continued From page 14	2 830		

and (specialized) hoyer lift for transfers." These tasks were assigned to nursing assistants. There was no guidance on how nursing assistants were to "work with resident". The care plan was also revised on 6/16/16, to note "Encourage resident to get up daily and reposition/offload. Resident prefers to stay in bed-Refuses." There was no guidance on handling R35's refusal to get out of bed or to review risks and benefits of this refusal. There were no interventions to get her out of bed despite concerns related to sling, such as approach to use or methods to make her more comfortable. There were no interventions to mitigate the potential impact of not getting out of bed because of concerns related to sling, such as skin, comfort, mobility, social and emotional issues.

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.

Progress note, dated 6/15/15, revealed "coccyx-Pressure: Length=2.0, Width= 0.1, Depth=0, Stage II Open Slit-superficial." The prior skin assessment, dated 6/7/16, revealed no skin concerns. A progress note from 6/20/16, was scanned and emailed to survey team following the survey. The note revealed "Area on crease of upper coccyx assessed. Area is closed at this

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2 830	Continued From page 15 time. Area determined to be caused by incontinence, not pressure." SUGGESTED METHOD OF CORRECTION: The director of nursing [DON] and social worker [LSW] or designee could review, revise and/or develop a procedure for monitoring residents for changes and concerns, communicating changes and concerns to the appropriate staff and following up on changes and concerns. DON and LSW or designee could educate all staff on this procedure. DON and LSW or designee could audit for continued compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
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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21805	Continued From page 16 Findings include: Review of the minimum data set (MDS) dated 5/7/16, revealed R35 was cognitively intact, had no delusions or hallucinations, behaviors related to rejection of care and required extensive assistance of at least two staff for transfers (moving between surface to or from: bed, chair, wheelchair, standing position, excluding to/from bath/toilet). 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 reported it was heavy and when the nursing assistants (NA) tried to use it with her on Sunday it was very uncomfortable and would not fit in her wheelchair. R35 explained that she had physical health concerns which made it difficult to use other slings in the facility. R35 reported the staff had tried to transfer her with another lift and sling and it almost tipped. R35 reported when she thought about the whole situation she started to well up, and was observed to well up at this time. R35 reported she felt guilty and like she had done something wrong that required the facility to spend so much money on a sling for her. R35	21805		

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reported she told staff she hoped they got a refund on the sling and they told her they did not know and had to get corporate approval for the sling because it was $700. R35 added she could not get out of bed today to spend time with a family member who visited earlier in the day. R35 reported the nursing assistants had come in and saw she was emotional in the last few days. R35 reported no nurse, physical therapist or occupational therapist had come in to assess sling and lift use for her. Only nursing assistants had worked with her and the new sling. R35 reported she felt angry no one was helping her get out of bed and resolve problems with the sling. At 1:58 p.m. R35 reported a nursing staff member and a business staff member had told her the cost of the new sling. (Mechanical lifts are devices used to assist staff in transferring residents. For some mechanical lifts, a sling is used to hold residents during the transfer.)

On 06/16/2016, at 8:54 a.m. a licensed practical nurse working on R35's unit, (LPN)-A, was asked about R35 not getting out of bed. LPN-A reported "it's a commotion" and explained that certain lifts went with certain slings and "(R35) does not like any of them." LPN-A explained the facility had purchased one for her that cost $700 and R35 complained that it was too big and would not fit in R35's wheelchair. LPN-A reported she did not tell the director of nursing (DON) about R35's concern and instead believed R35 would have to initiate the conversation with the DON as R35 was alert and oriented. LPN-A reported she told R35 "my hands are tied, this is what I have." LPN-A reported she told R35 the sling was expensive, but did not tell R35 the cost. During the same interview, the DON reported she had assessed the use of the new sling and lift with R35 but did not document this assessment. DON

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21805	Continued From page 18	21805		

and LPN-A reported R35 had not been out of bed for two days. At 10:01 a.m. DON reported it would be inappropriate for staff to discuss cost of the sling with R35.

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.

Review of R35's care plan revealed no interventions related to R35's concerns regarding her sling until 6/16/16, after surveyor intervention.

SUGGESTED METHOD OF CORRECTION: The director of nursing [DON] and social worker [LSW] or designee could develop a policy and procedure on appropriate interactions with residents and treating residents with dignity and respect. The DON and LSW or designee could educate all staff on appropriate interactions with residents and treating residents with dignity and respect. DON and LSW or designee could audit for continued compliance and report results to the

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	00776	A. BUILDING: _____ B. WING _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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21805	Continued From page 19 facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights 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. On 6/15/16, at 8:43 a.m. during resident interview, call light was not observed within R97's reach if she needed assistance from staff. It was located hanging from wall call light box onto the floor next to R97's bed. Registered nurse (RN)-A was walking down the hall and came into R97's room. R97 was seated in wheelchair next to room door. RN-A verified call light was not within reach, draped call light cord over bed, brought it over to R97, and clipped it to her sweater. RN-A asked R97 if she could push red call light and R97 pushed red button. When asked if R97 could use the call light, RN-A stated she "uses button at	21810		

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21810	Continued From page 20 times and does need it to be there for her to use it." R97's face sheet included diagnoses of unspecified sequelae of cerebral infarction and generalized muscle weakness. 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. On 6/15/16, at 3:27 p.m. director of nursing (DON) stated her expectation was that call light was in place for resident to reach it. Review of the facility's call light use policy dated 2006, indicated "11. Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could assure that policies and procedures are revised, up to date, implemented and monitored to assure resident call lights are within reach and that residents needs are met. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21810		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate	21830		

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21830	Continued From page 21	21830		

in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance

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directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper

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21830	Continued From page 23 or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess bathing frequency preferences for 1 of 1 resident reviewed for choices (R7). Findings include: R7's minimum data set (MDS) dated 5/2/16, revealed R7 had severe cognitive impairment, had no behaviors related to rejection of care and required physical help from staff, limited to transfer only for bathing. 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 request if they wanted to be bathed more than	21830		

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21830	Continued From page 24 once each week. R7 was getting bathed once each week. At 3:08 p.m. DON reported there was no system to assess and document the number of bathing times residents wanted each week. There was no documentation about the bathing preferences of R7. On 6/15/16, at 3:16 p.m. the social worker, (LSW)-A reported there was no documentation or system related to assessing resident bathing preferences. Review of the bath aide schedule, undated, revealed R7 was scheduled to be assisted with bathing once each week. Review of the point of care bathing information from 5/1/16, to 6/15/16, revealed R7 was bathed on 5/1, 5/10, 5/15, 5/29, 6/5 and 6/12. SUGGESTED METHOD OF CORRECTION: The director of nursing [DON] and social worker [LSW] or designee could develop a procedure to ensure resident daily schedule preferences, including bathing preferences, are assessed, care planned and implemented. DON and SW or designee could educate all staff about honoring resident choices. DON and LSW or designee could audit for continued compliance and report results to the facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		