Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2024

Administrator
Sunnyside Care Center
16561 Us Highway 10
Lake Park, MN 56554-9302

RE: CCN: 245597
Cycle Start Date: March 6, 2024

Dear Administrator:

On March 6, 2024, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

If substantial compliance with the regulations is not verified by June 6, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by September 6, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

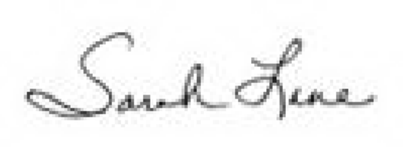
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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March 14, 2024

Administrator
Sunnyside Care Center
16561 Us Highway 10
Lake Park, MN 56554-9302

Re: State Nursing Home Licensing Orders
Event ID: U58P11

Dear Administrator:

The above facility was surveyed on March 4, 2024 through March 6, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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.

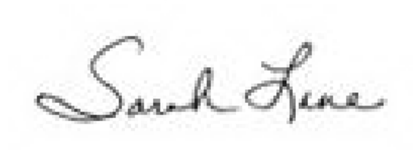
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING _____ B. WING _____	03/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/4/24 to 3/6/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/4/24 to 3/6/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550		4/20/24

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

Electronically Signed | 03/21/2024

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

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F 550	Continued From page 1 The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.	F 550		

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F 550	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 1 residents (R16) who received assistance with eating in the dining room. Findings Include: R16's quarterly Minimum Data Set (MDS) dated 1/12/24, identified R16 had severe cognitive impairment and had diagnoses which included: anxiety, depression, cerebral vascular accident (CVA/stroke) hemiplegia (paralysis on one side of body), and hemiparesis (weakness on one side of body) R16's care plan revised 3/4/24, identified R16 had self-care performance deficit related to hemiplegia and hemiparesis affecting left non-dominant side. R16's interventions included assistance with hygiene, bathing and dressing. R16's care plan identified R16 had potential for altered nutritional status related to CVA and required set up and assistance at times with eating. R16's care plan identified R16 received hospice care. During an observation on 3/5/24 at 8:56 a.m., R16 sat in a high back wheelchair in the dining room at a table. Nursing assistant (NA)-B stood near R16's right side, and provided 2 spoonful of eggs while he remained standing on R16's right side. NA-B went to the other side of the table, sat on a stool next to another resident and assisted the other resident. At 9:00 a.m., NA-B stood up, walked over to R16 and stood at R16's right side and provided R16 a spoonful of eggs. NA-B	F 550	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.¿ R16 Careplan reviewed for dignified dining experience. Education provided to nursing assistant who fed R16 breakfast. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.¿ Educate all licensed, unlicensed nursing staff and feeding assistants regarding policy and procedure for resident dignified dining experience. All current resident meal experiences were reviewed and revealed a dignified dining experience. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Current Policy and Procedure reviewed to ensure dignified dining experience for all residents. Educate all licensed, unlicensed nursing and feeding assistants regarding policy	

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F 550	Continued From page 3 placed the fork into R16's bacon, asked R16 if he wanted the bacon and placed the bacon back onto the plate. NA-B provided R16 a drink of soda in a can with a straw. NA-B remained standing with left hand resting on the back of R16's wheelchair while providing R16 with spoons full of eggs and drinks. At 9:05 a.m. NA-B asked R16 if done, removed R16's dishes from the table, removed R16's clothing protector and transported R16 out of the dining room. During an interview on 3/5/24 at 10:16 a.m., NA-B stated the usual process was to be seated while assisting residents with eating. NA-B indicated it was important not to stand while assisting residents with eating and indicated NA-B should have sat while assisting R16 in order to pay attention to R16 and be at eye level. During an interview on 3/6/24 at 12:05 p.m., registered nurse (RN)-A stated staff were expected to be seated while assisting residents with eating and have conversations with them. RN-A indicated it was important to give the residents their full attention and be at eye level. RN-A verified it was not a dignified practice to stand while assisting residents with eating. During an interview on 3/6/24 at 12:14 p.m., director of nursing (DON) indicated staff were expected to be seated by residents while assisting with eating as it was important to maintain dignity and promote safety. The facility policy titled Serving A Meal dated 8/1/23, identified when residents required assistance with consuming their meal, employees would remain at the table seated, giving their attention to the resident during the duration of the	F 550	and procedure for resident dignified dining experience. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.¿ Audit 10% of meals to ensure dignified dining experience for residents (weekly x4 weeks, then monthly x2 months. Will have QAPI review the results and make recommendations to continue audits as needed. Corrective action will be monitored by DON or designee. 5. The date that each deficiency will be corrected 4/20/2024	

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F 550	Continued From page 4 meal.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 2 of 2 resident (R26, R9) who were observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings include: R26 R26's admission Minimum Data Set (MDS) dated 12/13/23, identified R26 was cognitively intact and had diagnoses which included: multiple sclerosis (chronic disease that affects central nervous system) hemiplegia (paralysis on one side of body), hemiparesis (weakness on one side of body) and chronic obstructive pulmonary disease (COPD/chronic lung disease that cause airflow and breathing problems). R26's MDS identified R26 was dependent for self care and mobility. R26's care plan revised 12/20/23, identified R26 had an activity of daily living (ADL) self-care performance deficit related to disease processes. R26's care plan interventions included dependence on staff for bathing, dressing, and	F 554	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.¿ Orders obtained and nursing assessments completed for affected residents for self administration of nebulizing medications. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.¿ Audit 100% of residents receiving nebulizing medications for need for self-administration assessments and orders. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿Any new orders for scheduled nebulizing medications will have nursing assessment for self administration completed when processing order. If resident is able to self administration medication, order will be	4/20/24

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F 554	Continued From page 5 personal hygiene. Identified R26 had a cerebral infarction (CVA/stroke) which affected R26's left, non-dominant side. R26's Order Summary Report signed 3/1/24, included orders for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram (MG)/3 milliliter (ML) 1 vial inhale orally four times a day for while awake. R26's Order Summary Report lacked an order to self administer medication. R26's medical record lacked documentation of a self-administration of medication (SAM) assessment completed. During an observation on 3/6/24 at 7:13 a.m., licensed practical nurse (LPN)-A administered R26's oral medications and topical medication. At 7:21 a.m. LPN-A opened R26's vial of Ipratropium-Albuterol inhalation solution and poured it into the nebulizer cup. LPN-A applied R26's nebulizer mask, turned on the nebulizer machine, set a timer on her watch and informed R26 she would return. LPN-A exited R26's room and went down to the end of the hall to the medication cart. LPN-A set up another resident's insulin medication, went down a different hallway and administered the insulin. At 7:38 a.m. LPN-A was observed exiting R26's room and stated she had rinsed the nebulizer out. LPN-A stated she was unaware if R26 had an order or SAM assessment for the nebulizer medication. During an interview on 3/6/24 at 7:39 a.m., registered nurse (RN)-A and LPN-A confirmed R26 did not have an order for self administration of medication, including the nebulizer. RN-A	F 554	obtained. Resident will not be left alone with nebulizing medication until self administration assessment and orders are completed. Educate all licensed and unlicensed nursing staff who administer medication on policy and procedure regarding resident self administration of medication. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.¿ Audit 10% of nebulizing medication orders and self administration assessments ordered and completed (weekly x4 weeks, then monthly x2 months. Will have QAPI review the results and make recommendations to continue audits as needed. Corrective action will be monitored by DON or designee. 5. The date that each deficiency will be corrected 4/20/2024	

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F 554	Continued From page 6 verified no residents at the facility currently had a SAM assessment completed and RN-A indicated she expected staff would remain in the room while any resident received a nebulizer medication. R9 R9's quarterly Minimum Data Set (MDS) dated 12/13/23, indicated R9 had mild cognitive impairment and had diagnoses which included hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body), aphasia (loss of ability to understand or express speech, caused by brain damage), and cerebral vascular accident (CVA) (Stroke). Indicated R9 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. Review of R9's electronic health record (EHR) revealed a SAM assessment had not been completed and R9 did not have an order for self administration of medications. R9's Physician Telephone Orders dated 2/12/24, and signed 2/20/24, directed staff to administer Ipratropium-albuterol inhalation solution DuoNeb (medication used to relax the muscles in the airways and increase air flow to the lungs) four times daily (QID) and every four hours as needed for congestion.	F 554		

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F 554	Continued From page 7 R9's Medication Administration Record dated 2/12/24 to 3/6/24, indicated R9 had been taking (DuoNeb) 0.5-2.5 3 milligrams (mg) per three milliliters (ml) four times per day. R9's care plan dated 2/24, indicated R9 had limited mobility and required staff assistance and supervision with activities of daily living (ADL's). During a continuous observation on 3/6/24 at 7:20 a.m., R9 was seated in his recliner in his room with a mask on his face and a nebulizer running. No staff were observed in R9's room. At 7:26 a.m., trained medication aide (TMA)-A entered R9's room and shut off the nebulizer machine and removed the mask from R9's face. During an interview on 3/6/24 at 7:27 a.m., R9 stated he had been receiving the DuoNeb treatments for a few weeks now a few times a day. R9 indicated he had not been taught how to use the nebulizer machine. R9 verified nursing staff did not remain in the room while the treatment was being administered. R9 stated nursing staff turned on the nebulizer machine and placed the mask on his face and exited the room. During an interview on 3/6/24 at 7:30 a.m., TMA-A verified she had placed the nebulizer treatment on R9 and exited the room. TMA-A stated she was unsure if a SAM assessment had been completed for R9. TMA-A stated she did not have time to sit with R9 while he received his nebulizer so she would place the nebulizer on R9, turned on the machine, left the room and returned when the nebulizer was done. In addition, TMA indicated sometimes R9 would remove the mask himself and sometimes she would have to	F 554		

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F 554	Continued From page 8 remove the mask for R9 when the nebulizer was completed. During an interview on 3/6/24 at 7:39 a.m., registered nurse (RN)-A confirmed R9 and R26 did not have a SAM assessment for their nebulizer treatments. RN-A stated none of the current residents had a SAM assessment for nebulizer's as they were not safe to self administer the nebulizers. RN-A indication her expectation was nursing staff would have stayed in the room with R9 and R26 while they received the nebulizer treatments to ensure R9 and R26 received the nebulizer treatments appropriately. During an interview on 3/6/24 at 7:42 a.m., director of nursing (DON) verified R9 and R26 did not have SAM assessments. DON indicated if the resident did not have a SAM assessment or physician's orders, staff were expected to remain with the resident during the entire nebulizer administration. Review of a facility policy titled Resident Self-Administration of Medication dated 8/1/23,identified a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Further indicated resident's preference would be documented on the appropriate form and placed in the medical record.	F 554		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		4/20/24

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F 641	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) correctly for 1 of 1 residents (R79) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2023, identified Section 00110C1: Oxygen Therapy Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. R79's admission Minimum Data Set (MDS) dated 2/26/24, Section O:Special Treatments, Procedures, and Programs. Question 001000 C identified R79 had not received oxygen in the last 14 days. Review of R79's care plan updated 3/5/24, indicated R79 required oxygen with the use of his continuous positive airway pressure (CPAP) (a machine that used mild air pressure to keep breathing airways open while sleeping). Review of R79's signed physician orders dated 2/20/24, identified R79 was to use two liters of oxygen at night with a CPAP machine. During an interview on 3/5/24 at 9:05 a.m., R79 pointed to an oxygen concentrator in his room and stated he used oxygen every night with that	F 641	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.¿ Modification of MDS to reflect accurate oxygen use. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.¿ Audit most recent MDS of residents in facility to ensure correct code of question O01000C. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿Education to each person responsible for completing the MDS to ensure they understand the coding guidelines for when to code oxygen use. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.¿ Audit 10% of resident charts (weekly x4 weeks, then monthly x2 months.) that have completed MDS during the prior week to ensure accurate MDS coding for Oxygen use. Will have QAPI review the	

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F 641	Continued From page 10 machine and pointed to a CPAP machine. Review of R79's admission progress note dated 2/21/24, identified R79 slept with a CPAP with oxygen attached. During an interview on 3/5/24 at 11:06 a.m., MDS coordinator verified R79 utilized oxygen at two liters at night with a CPAP machine. MDS coordinator verified Section O of R79's MDS dated 2/26/24, had not been coded correctly. MDS stated her expectation would have been the MDS would have been coded correctly. During an interview on 3/5/24 at 3:41 p.m., director of nursing (DON) verified R79 had received oxygen with a CPAP machine at night. DON confirmed R79's MDS dated 2/26/24, had not been coded accurately. DON stated her expectation would have been for staff to complete the MDS correctly. Review of a facility policy titled MDS 3.0 Completion dated 8/1/23, identified residents were assessed, used a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Indicated persons completing part of the assessment must attest to the accuracy of the section they completed by signature.	F 641	results and make recommendations to continue audits as needed. Corrective action will be monitored by DON or designee. 5.The date that each deficiency will be corrected 4/20/2024	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		4/20/24

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F 688	Continued From page 11 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services to prevent potential decrease in range of motion (ROM) for 1 of 1 residents (R9) reviewed who required range of motion for restorative nursing exercises. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/13/23, indicated R9 had mild cognitive impairment and had diagnosis which included hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body), aphasia (loss of ability to understand or express speech, caused by brain damage), and cerebral vascular accident (CVA) (Stroke). Indicated R9 required extensive assistance with bed mobility, transfers, and toileting. R9's Significant Change Care Area Assessment (CAA) dated 3/17/23, identified R9 required extensive assistance with activities of daily living	F 688	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.¿ Therapy eval only completed with resident to assessment for decrease in ROM. Restorative nursing program put into place for ROM for resident. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.¿ Audit 100% of residents who are to have ROM exercises included in restorative nursing program. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿Implement Communication tool between	

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F 688	Continued From page 12 (ADL's) which included dressing, bed mobility, transfers and toileting. R9's current care plan dated 3/23, indicated passive range of motions (PROM) and active range of motion (AROM) would be provided. Review of Occupational Therapy (OT) discharge summary dated 12/20/23, identified discharge recommendations: patient to remain at same skilled nursing facility (SNF) with 24 hour supervision and cares with restorative nursing program (RNP) including PROM 10 reps to right arm daily to maintain range of motion (ROM) and endurance. In addition, left upper extremity exercises with theraband were to be completed daily. Review of R9's progress notes lacked any indication of a RNP. During an observation on 3/4/24 at 12:35 p.m., R9 was seated in his recliner in his room and used his left arm to pick up his right arm to place it on the armrest of the recliner. During an interview on 3/4/24 at 12:39 p.m., R9 indicated he had limited ROM in his right arm and right leg. R9 stated staff had not been assisting R9 with any ROM exercises. During an interview on 3/6/24 at 8:15 a.m., nursing assistant (NA)-B indicated R9 had very limited ROM on his right side and required staff assistance with ADL's. NA-B stated he had performed RNP for residents in the past however was unaware of any ROM programs currently in place for R9.	F 688	therapy and nursing when resident is discharged form therapy. Communication tool includes if restorative program is recommended. Educate all licensed nursing staff on importance of restorative nursing programming and communication tool. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.¿ Audit 10% of therapy discharges for requirement of restorative nurse program with ROM exercises in week prior. Audit weekly x4 weeks, monthly x2 months Will have QAPI review the results and make recommendations to continue audits as needed. Corrective action will be monitored by DON or designee. 5. The date that each deficiency will be corrected 4/20/2024	

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F 688	Continued From page 13 During an interview on 3/6/24 at 8:20 p.m., NA-A indicated R9 had limited ROM on his right side. NA-A stated she was not aware of any RNP programs currently in place for R9. During an interview on 3/6/24 at 8:25 a.m., registered nurse (RN)-A indicated R9 had right sided hemiplegia and required staff assistance for ADL's. RN-A confirmed R9 had an OT recommendation for an RNP program to maintain ROM. RN-A verified the recommendation had not been communicated to the staff and therefore, had not been completed. RN-A stated her expectation would have been the RNP would have been communicated to staff and started upon R9's discharge from OT to prevent further loss of ROM to his right side. During an interview on 3/6/24 at 8:59 a.m., therapy director (TD) verified R9 had been discharged from OT on 2/20/24, and was to have a RNP to his right arm to prevent further loss of ROM. TD stated it would have been important to implement the RNP for R9 to prevent a decline related to further loss of ROM. During an interview on 3/6/24 at 10:05 a.m., director of nursing DON stated she was unaware R9 had not been receiving restorative services per therapy recommendations. DON indicated her expectation was staff would have followed therapy recommendations. Review of a facility policy titled Restorative Nursing Programs dated 8/1/23, identified restorative nursing programs referred to nursing interventions that promoted the resident's ability to live as independently and safely as possible and actively focused on achieving and	F 688		

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F 688	Continued From page 14 maintaining optimal physical, mental, and psychosocial functioning. Identified the discharging therapist would communicate to the appropriate restorative aide the provisions of the residents restorative nursing plan, and provide any necessary training to carry out the plan. .	F 688		
F 880 SS=E	. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		4/20/24

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F 880	Continued From page 15 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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F 880	Continued From page 16 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal laundry was transported in a manner that prevented risk of contamination for 2 of 3 hallways observed for linen transportation. In addition, the facility failed to complete hand hygiene during linen delivery and ensure safe delivery of beverages during dining observation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of	F 880	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.¿ Educate team members handling beverages and linens, and hand hygiene when handling linens and beverages. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.¿ Educate team members handling beverages and linens, and hand hygiene when handling linens and beverages.	

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F 880	Continued From page 17 contamination by dust, debris, soiled linens or soiled items. In addition, CDC Handwashing in Communities: Clean Hands Save Lives updated 7/18/22, identified handwashing was the most important thing to prevent food poisoning. During an observation on 3/4/24 at 2:58 p.m., in the 100 hallway nursing assistant (NA)-C pushed an uncovered cart that contained clean linen down the hallway. NA-C sanitized hands and removed a washcloth and a towel from the uncovered cart and delivered the items to R18's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart as a resident wheeled by the cart. NA-C delivered the items to R24's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R14's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R1's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart as a staff member walked by the cart. NA-C delivered items to R25's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R4's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R12's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R15's room. During an observation on 3/5/24 at 12:08 p.m., in the resident dining room Minimum Data Set	F 880	3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. ¿All clean linens in hallway to be covered with sheet. Instructions posted on linen cart. Educate all team members on infection control practices regarding handling of linens and beverages. Educate all team members on hand hygiene policy and procedure. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.¿ Audit 10% of linen pass and beverage pass weekly x4 weeks, monthly x 2 months. Will have QAPI review the results and make recommendations to continue audits as needed. Corrective action will be monitored by DON or designee. 5. The date that each deficiency will be corrected 4/20/2024	

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F 880	Continued From page 18 (MDS) coordinator poured two glasses of milk for R20. MDS coordinator placed her right hand around one of the glasses and placed her left hand over the top part of one glass (the area you drink from) and proceeded to carry the two glasses of milk across the dining room. MDS coordinator placed the two glasses on the table in front of R20 who proceeded to drink from the glass the MDS coordinator held in her left hand. During an interview on 3/5/24 at 1:46 p.m., MDS coordinator stated her normal practice was to place her hands around the center of the glass when carrying a glass. MDS coordinator stated it was important not to touch the area of the glass a resident drank from to prevent infections. During an observation on 3/5/24 at 2:46 p.m., NA-D placed several washcloths and towels on an uncovered cart and placed the cart in the hallway near the nurses' station as two staff members walked by the uncovered cart. At 3:11 p.m., NA-D returned to the uncovered cart and pushed the cart down the 200 hallway. In addition,NA-C brought an empty cart down the hallway. NA-C proceeded to remove a washcloth and towel from the uncovered linen cart and delivered the items to R11's room. NA-C returned to the hallway with a dirty water pitcher and placed it on the empty cart and moved the uncovered linen cart down the hallway. NA-C proceeded to remove a washcloth and towel from the uncovered linen cart and delivered the items to R2's room. NA-C returned to the hallway with a dirty water pitcher and placed it on the cart with the other water pitcher. NA-C proceeded to remove a washcloth and towel from the uncovered linen cart and delivered them to R16's room as a visitor walked by the cart. NA-C	F 880		

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F 880	Continued From page 19	F 880		

returned to the hallway with a dirty water pitcher and placed it on the cart with the other water pitchers. At no time did NA-C perform hand hygiene during the above observation.

During an interview on 3/5/24 at 3:12 p.m., NA-D stated her normal practice was to pass clean linen on a clean uncovered cart. NA-D stated it was important to cover the linen cart to prevent contamination of the linens.

During an interview on 3/5/24 at 3:16 p.m., NA-C stated her normal process was to sanitize her hands before passing linen from a clean uncovered cart. NA-C stated she should have sanitized her hands while passing linen and the cart should have been covered to prevent possible cross contamination.

During an interview on 3/5/24 at 3:38 p.m., director of nursing (DON) stated her expectation was staff would perform hand hygiene, cover linens during transport, and staff should not be touching any areas of the glass the resident drinks from.

A facility policy titled Infection Prevention and Control Manual Environmental Services/Housekeeping/Laundry dated 2020, indicated the facility was to provide clean, fresh linen to each resident and prevent contamination. Identified clean linen was transported in a clean, covered cart with a solid bottom to prevent contamination while being moved through the facility.

A facility policy titled General Food Preparation and Handling dated 8/1/23, indicated food items were to be prepared to be free of injurious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING _____ B. WING _____	03/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 organisms and substances. Indicated staff were to handle utensils, cups, glasses, and dishes in such as way as to avoid touching surfaces that food or drink will come in contact with.	F 880		

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	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/05/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/05/2024. At the time of this survey Sunnyside Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S PC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CM'S-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE PC, 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. IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (AK TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2024

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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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Main Building 1975 1-story no basement Type II (111). In 2004 an entrance/ dayroom was added. 1-story no basement Type V (111). Since this addition was not separated by a 2-hour fire barrier, the entire facility is considered V (111) and surveyed as one building. The facility is divided by three smoke barriers creating four smoke compartments. The facility is fully sprinkler protected and has a manual fire alarm system with corridor smoke detection and sleeping room smoke detection,	K 000		

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K 000	Continued From page 2 which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 27 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced	K 324		4/20/24

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K 324	Continued From page 3 by: Based on observation, a review of available documentation, and staff interview, the facility failed to install proper protection for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/05/2024 between 11:45 AM and 1:30 PM, it was revealed by observation that a stove in the Coffee Shop did not have a timer, not exceeding 120 minutes, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 324	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The power source cords to the oven has been removed from the oven and the oven is no longer in service. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: This was the only electric oven in the Sunnyside facility. All team members will be educated that the electric oven is inoperable and does not have a timer. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: A sign will be posted above the oven indicating the oven is inoperable. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The maintenance supervisor will audit to ensure a power source has not been replaced weekly x3 then monthly x6 to ensure compliance. Results will be reviewed at QAPI to determine if there is an ongoing need to continue audits beyond this timeframe. Corrective Action will be monitored by: Maintenance Supervisor or designee 5. The actual or proposed date for completion of the remedy. 04/20/2024	

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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: On 3/4/24 to 3/6/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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. 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) correctly for 1 of 1 residents (R79) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2023, identified Section 00110C1: Oxygen Therapy Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. R79's admission Minimum Data Set (MDS) dated 2/26/24, Section O:Special Treatments, Procedures, and Programs. Question 001000 C identified R79 had not received oxygen in the last 14 days.	2 550	Corrected	4/4/24

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2 550	Continued From page 3 Review of R79's care plan updated 3/5/24, indicated R79 required oxygen with the use of his continuous positive airway pressure (CPAP) (a machine that used mild air pressure to keep breathing airways open while sleeping). Review of R79's signed physician orders dated 2/20/24, identified R79 was to use two liters of oxygen at night with a CPAP machine. During an interview on 3/5/24 at 9:05 a.m., R79 pointed to an oxygen concentrator in his room and stated he used oxygen every night with that machine and pointed to a CPAP machine. Review of R79's admission progress note dated 2/21/24, identified R79 slept with a CPAP with oxygen attached. During an interview on 3/5/24 at 11:06 a.m., MDS coordinator verified R79 utilized oxygen at two liters at night with a CPAP machine. MDS coordinator verified Section O of R79's MDS dated 2/26/24, had not been coded correctly. MDS stated her expectation would have been the MDS would have been coded correctly. During an interview on 3/5/24 at 3:41 p.m., director of nursing (DON) verified R79 had received oxygen with a CPAP machine at night. DON confirmed R79's MDS dated 2/26/24, had not been coded accurately. DON stated her expectation would have been for staff to complete the MDS correctly. Review of a facility policy titled MDS 3.0 Completion dated 8/1/23, identified residents were assessed, used a comprehensive assessment process, in order to identify care	2 550		

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2 550	Continued From page 4 needs and to develop an interdisciplinary care plan. Indicated persons completing part of the assessment must attest to the accuracy of the section they completed by signature. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced	2 890		4/4/24

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2 890	Continued From page 5 by: Based on observation, interview and document review, the facility failed to provide range of motion services to prevent potential decrease in range of motion (ROM) for 1 of 1 residents (R9) reviewed who required range of motion for restorative nursing exercises. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/13/23, indicated R9 had mild cognitive impairment and had diagnosis which included hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body), aphasia (loss of ability to understand or express speech, caused by brain damage), and cerebral vascular accident (CVA) (Stroke). Indicated R9 required extensive assistance with bed mobility, transfers, and toileting. R9's Significant Change Care Area Assessment (CAA) dated 3/17/23, identified R9 required extensive assistance with activities of daily living (ADL's) which included dressing, bed mobility, transfers and toileting. R9's current care plan dated 3/23, indicated passive range of motions (PROM) and active range of motion (AROM) would be provided. Review of Occupational Therapy (OT) discharge summary dated 12/20/23, identified discharge recommendations: patient to remain at same skilled nursing facility (SNF) with 24 hour supervision and cares with restorative nursing program (RNP) including PROM 10 reps to right arm daily to maintain range of motion (ROM) and endurance. In addition, left upper extremity	2 890	Corrected	

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2 890	Continued From page 6 exercises with theraband were to be completed daily. Review of R9's progress notes lacked any indication of a RNP. During an observation on 3/4/24 at 12:35 p.m., R9 was seated in his recliner in his room and used his left arm to pick up his right arm to place it on the armrest of the recliner. During an interview on 3/4/24 at 12:39 p.m., R9 indicated he had limited ROM in his right arm and right leg. R9 stated staff had not been assisting R9 with any ROM exercises. During an interview on 3/6/24 at 8:15 a.m., nursing assistant (NA)-B indicated R9 had very limited ROM on his right side and required staff assistance with ADL's. NA-B stated he had performed RNP for residents in the past however was unaware of any ROM programs currently in place for R9. During an interview on 3/6/24 at 8:20 p.m., NA-A indicated R9 had limited ROM on his right side. NA-A stated she was not aware of any RNP programs currently in place for R9. During an interview on 3/6/24 at 8:25 a.m., registered nurse (RN)-A indicated R9 had right sided hemiplegia and required staff assistance for ADL's. RN-A confirmed R9 had an OT recommendation for an RNP program to maintain ROM. RN-A verified the recommendation had not been communicated to the staff and therefore, had not been completed. RN-A stated her expectation would have been the RNP would have been communicated to staff and started upon R9's discharge from OT to prevent further	2 890		

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2 890	Continued From page 7 loss of ROM to his right side. During an interview on 3/6/24 at 8:59 a.m., therapy director (TD) verified R9 had been discharged from OT on 2/20/24, and was to have a RNP to his right arm to prevent further loss of ROM. TD stated it would have been important to implement the RNP for R9 to prevent a decline related to further loss of ROM. During an interview on 3/6/24 at 10:05 a.m., director of nursing DON stated she was unaware R9 had not been receiving restorative services per therapy recommendations. DON indicated her expectation was staff would have followed therapy recommendations. Review of a facility policy titled Restorative Nursing Programs dated 8/1/23, identified restorative nursing programs referred to nursing interventions that promoted the resident's ability to live as independently and safely as possible and actively focused on achieving and maintaining optimal physical, mental, and psychosocial functioning. Identified the discharging therapist would communicate to the appropriate restorative aide the provisions of the residents restorative nursing plan, and provide any necessary training to carry out the plan. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide a resident restorative nursing program, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of the restorative nursing program to ensure the residents programs are completed consistently. TIME PERIOD FOR CORRECTION: Twenty-one	2 890		

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2 890	Continued From page 8 (21) days.	2 890		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal laundry was transported in a manner that prevented risk of contamination for 2 of 3 hallways observed for linen transportation. In addition, the facility failed to complete hand hygiene during linen delivery and ensure safe delivery of beverages during dining observation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. In addition, CDC Handwashing in Communities: Clean Hands Save Lives updated 7/18/22, identified handwashing was the most important thing to prevent food poisoning. During an observation on 3/4/24 at 2:58 p.m., in the 100 hallway nursing assistant (NA)-C pushed an uncovered cart that contained clean linen down the hallway. NA-C sanitized hands and	21375	Corrected	4/4/24

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21375	Continued From page 9 removed a washcloth and a towel from the uncovered cart and delivered the items to R18's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart as a resident wheeled by the cart. NA-C delivered the items to R24's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R14's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R1's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart as a staff member walked by the cart. NA-C delivered items to R25's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R4's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R12's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and towel from the uncovered cart and delivered the items to R15's room. During an observation on 3/5/24 at 12:08 p.m., in the resident dining room Minimum Data Set (MDS) coordinator poured two glasses of milk for R20. MDS coordinator placed her right hand around one of the glasses and placed her left hand over the top part of one glass (the area you drink from) and proceeded to carry the two glasses of milk across the dining room. MDS coordinator placed the two glasses on the table in front of R20 who proceeded to drink from the glass the MDS coordinator held in her left hand. During an interview on 3/5/24 at 1:46 p.m., MDS	21375		

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21375	Continued From page 10 coordinator stated her normal practice was to place her hands around the center of the glass when carrying a glass. MDS coordinator stated it was important not to touch the area of the glass a resident drank from to prevent infections. During an observation on 3/5/24 at 2:46 p.m., NA-D placed several washcloths and towels on an uncovered cart and placed the cart in the hallway near the nurses' station as two staff members walked by the uncovered cart. At 3:11 p.m., NA-D returned to the uncovered cart and pushed the cart down the 200 hallway. In addition,NA-C brought an empty cart down the hallway. NA-C proceeded to remove a washcloth and towel from the uncovered linen cart and delivered the items to R11's room. NA-C returned to the hallway with a dirty water pitcher and placed it on the empty cart and moved the uncovered linen cart down the hallway. NA-C proceeded to remove a washcloth and towel from the uncovered linen cart and delivered the items to R2's room. NA-C returned to the hallway with a dirty water pitcher and placed it on the cart with the other water pitcher. NA-C proceeded to remove a washcloth and towel from the uncovered linen cart and delivered them to R16's room as a visitor walked by the cart. NA-C returned to the hallway with a dirty water pitcher and placed it on the cart with the other water pitchers. At no time did NA-C perform hand hygiene during the above observation. During an interview on 3/5/24 at 3:12 p.m., NA-D stated her normal practice was to pass clean linen on a clean uncovered cart. NA-D stated it was important to cover the linen cart to prevent contamination of the linens. During an interview on 3/5/24 at 3:16 p.m., NA-C	21375		

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21375	Continued From page 11 stated her normal process was to sanitize her hands before passing linen from a clean uncovered cart. NA-C stated she should have sanitized her hands while passing linen and the cart should have been covered to prevent possible cross contamination. During an interview on 3/5/24 at 3:38 p.m., director of nursing (DON) stated her expectation was staff would perform hand hygiene, cover linens during transport, and staff should not be touching any areas of the glass the resident drinks from. A facility policy titled Infection Prevention and Control Manual Environmental Services/Housekeeping/Laundry dated 2020, indicated the facility was to provide clean, fresh linen to each resident and prevent contamination. Identified clean linen was transported in a clean, covered cart with a solid bottom to prevent contamination while being moved through the facility. A facility policy titled General Food Preparation and Handling dated 8/1/23, indicated food items were to be prepared to be free of injurious organisms and substances. Indicated staff were to handle utensils, cups, glasses, and dishes in such as way as to avoid touching surfaces that food or drink will come in contact with. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including hand hygiene, delivering beverages and linen/laundry transport. Then the DON or designee could educate staff and perform audits to ensure the policies are being	21375		

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21375	Continued From page 12 followed. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 2 of 2 resident (R26, R9) who were observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings include: R26 R26's admission Minimum Data Set (MDS) dated 12/13/23, identified R26 was cognitively intact and had diagnoses which included: multiple sclerosis (chronic disease that affects central nervous system) hemiplegia (paralysis on one side of body), hemiparesis (weakness on one side of body) and chronic obstructive pulmonary disease (COPD/chronic lung disease that cause airflow and breathing problems). R26's MDS identified R26 was dependent for self care and mobility.	21565	Corrected	4/4/24

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21565	Continued From page 13 R26's care plan revised 12/20/23, identified R26 had an activity of daily living (ADL) self-care performance deficit related to disease processes. R26's care plan interventions included dependence on staff for bathing, dressing, and personal hygiene. Identified R26 had a cerebral infarction (CVA/stroke) which affected R26's left, non-dominant side. R26's Order Summary Report signed 3/1/24, included orders for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram (MG)/3 milliliter (ML) 1 vial inhale orally four times a day for while awake. R26's Order Summary Report lacked an order to self administer medication. R26's medical record lacked documentation of a self-administration of medication (SAM) assessment completed. During an observation on 3/6/24 at 7:13 a.m., licensed practical nurse (LPN)-A administered R26's oral medications and topical medication. At 7:21 a.m. LPN-A opened R26's vial of Ipratropium-Albuterol inhalation solution and poured it into the nebulizer cup. LPN-A applied R26's nebulizer mask, turned on the nebulizer machine, set a timer on her watch and informed R26 she would return. LPN-A exited R26's room and went down to the end of the hall to the medication cart. LPN-A set up another resident's insulin medication, went down a different hallway and administered the insulin. At 7:38 a.m. LPN-A was observed exiting R26's room and stated she had rinsed the nebulizer out. LPN-A stated she was unaware if R26 had an order or SAM assessment for the nebulizer medication.	21565		

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21565	Continued From page 14 During an interview on 3/6/24 at 7:39 a.m., registered nurse (RN)-A and LPN-A confirmed R26 did not have an order for self administration of medication, including the nebulizer. RN-A verified no residents at the facility currently had a SAM assessment completed and RN-A indicated she expected staff would remain in the room while any resident received a nebulizer medication. R9 R9's quarterly Minimum Data Set (MDS) dated 12/13/23, indicated R9 had mild cognitive impairment and had diagnoses which included hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body), aphasia (loss of ability to understand or express speech, caused by brain damage), and cerebral vascular accident (CVA) (Stroke). Indicated R9 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. Review of R9's electronic health record (EHR) revealed a SAM assessment had not been completed and R9 did not have an order for self administration of medications. R9's Physician Telephone Orders dated 2/12/24, and signed 2/20/24, directed staff to administer Ipratropium-albuterol inhalation solution DuoNeb (medication used to relax the muscles in the airways and increase air flow to the lungs) four times daily (QID) and every four hours as needed for congestion. R9's Medication Administration Record dated 2/12/24 to 3/6/24, indicated R9 had been taking	21565		

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21565	Continued From page 15 (DuoNeb) 0.5-2.5 3 milligrams (mg) per three milliliters (ml) four times per day. R9's care plan dated 2/24, indicated R9 had limited mobility and required staff assistance and supervision with activities of daily living (ADL's). During a continuous observation on 3/6/24 at 7:20 a.m., R9 was seated in his recliner in his room with a mask on his face and a nebulizer running. No staff were observed in R9's room. At 7:26 a.m., trained medication aide (TMA)-A entered R9's room and shut off the nebulizer machine and removed the mask from R9's face. During an interview on 3/6/24 at 7:27 a.m., R9 stated he had been receiving the DuoNeb treatments for a few weeks now a few times a day. R9 indicated he had not been taught how to use the nebulizer machine. R9 verified nursing staff did not remain in the room while the treatment was being administered. R9 stated nursing staff turned on the nebulizer machine and placed the mask on his face and exited the room. During an interview on 3/6/24 at 7:30 a.m., TMA-A verified she had placed the nebulizer treatment on R9 and exited the room. TMA-A stated she was unsure if a SAM assessment had been completed for R9. TMA-A stated she did not have time to sit with R9 while he received his nebulizer so she would place the nebulizer on R9, turned on the machine, left the room and returned when the nebulizer was done. In addition, TMA indicated sometimes R9 would remove the mask himself and sometimes she would have to remove the mask for R9 when the nebulizer was completed. During an interview on 3/6/24 at 7:39 a.m.,	21565		

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21565	Continued From page 16 registered nurse (RN)-A confirmed R9 and R26 did not have a SAM assessment for their nebulizer treatments. RN-A stated none of the current residents had a SAM assessment for nebulizer's as they were not safe to self administer the nebulizers. RN-A indication her expectation was nursing staff would have stayed in the room with R9 and R26 while they received the nebulizer treatments to ensure R9 and R26 received the nebulizer treatments appropriately. During an interview on 3/6/24 at 7:42 a.m., director of nursing (DON) verified R9 and R26 did not have SAM assessments. DON indicated if the resident did not have a SAM assessment or physician's orders, staff were expected to remain with the resident during the entire nebulizer administration. Review of a facility policy titled Resident Self-Administration of Medication dated 8/1/23,identified a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Further indicated resident's preference would be documented on the appropriate form and placed in the medical record. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review with staff current policies to ensure residents who are self administering medication had been assessed and were appropriate to administer their own medication, along with a physician's order for administration. The DON could audit resident to ensure assessment, and physician orders for self administration were in place.	21565		

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21565	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
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 a dignified dining experience for 1 of 1 residents (R16) who received assistance with eating in the dining room. Findings Include: R16's quarterly Minimum Data Set (MDS) dated 1/12/24, identified R16 had severe cognitive impairment and had diagnoses which included: anxiety, depression, cerebral vascular accident (CVA/stroke) hemiplegia (paralysis on one side of body), and hemiparesis (weakness on one side of body) R16's care plan revised 3/4/24, identified R16 had self-care performance deficit related to hemiplegia and hemiparesis affecting left non-dominant side. R16's interventions included assistance with hygiene, bathing and dressing. R16's care plan identified R16 had potential for altered nutritional status related to CVA and required set up and assistance at times with	21805	Corrected.	4/4/24

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21805	Continued From page 18 eating. R16's care plan identified R16 received hospice care. During an observation on 3/5/24 at 8:56 a.m., R16 sat in a high back wheelchair in the dining room at a table. Nursing assistant (NA)-B stood near R16's right side, and provided 2 spoonful of eggs while he remained standing on R16's right side. NA-B went to the other side of the table, sat on a stool next to another resident and assisted the other resident. At 9:00 a.m., NA-B stood up, walked over to R16 and stood at R16's right side and provided R16 a spoonful of eggs. NA-B placed the fork into R16's bacon, asked R16 if he wanted the bacon and placed the bacon back onto the plate. NA-B provided R16 a drink of soda in a can with a straw. NA-B remained standing with left hand resting on the back of R16's wheelchair while providing R16 with spoons full of eggs and drinks. At 9:05 a.m. NA-B asked R16 if done, removed R16's dishes from the table, removed R16's clothing protector and transported R16 out of the dining room. During an interview on 3/5/24 at 10:16 a.m., NA-B stated the usual process was to be seated while assisting residents with eating. NA-B indicated it was important not to stand while assisting residents with eating and indicated NA-B should have sat while assisting R16 in order to pay attention to R16 and be at eye level. During an interview on 3/6/24 at 12:05 p.m., registered nurse (RN)-A stated staff were expected to be seated while assisting residents with eating and have conversations with them. RN-A indicated it was important to give the residents their full attention and be at eye level. RN-A verified it was not a dignified practice to stand while assisting residents with eating.	21805		

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21805	Continued From page 19 During an interview on 3/6/24 at 12:14 p.m., director of nursing (DON) indicated staff were expected to be seated by residents while assisting with eating as it was important to maintain dignity and promote safety. The facility policy titled Serving A Meal dated 8/1/23, identified when residents required assistance with consuming their meal, employees would remain at the table seated, giving their attention to the resident during the duration of the meal. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement systems to ensure resident dignity was maintained. The facility could educate all staff on these systems. Random audits for dignity could be done to ensure ongoing compliance. The administrator or designee could take that audit results to the quality assurance group for review and further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		